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Chapter 8: Troubled talk and talk about troubles: Moral cultures of infant feeding in professional, policy and parenting discourse

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Introduction

This chapter examines the ways in which policy agendas and contemporary notions of the ‘good mother’ frame infant feeding practices, rendering them a site of moral and interactional trouble for mothers. Drawing on analysis of mothers’ talk with midwives during the first days of motherhood, the chapter explores the ways in which breastfeeding confers a positive maternal identity whilst choosing not to do so is associated with a deficit identity against which mothers’ struggle to present themselves as good parents. The chapter suggests that these encounters are important places to explore the ways in which ‘ordinary’ family practices are troubled by policy agendas which may conflict with women’s embodied experiences, culturally held ideas about feeding babies and contemporary notions about what constitutes a good mother and a healthy baby. A focus on these signal moments makes visible the ways in which policy agendas may negate the rich texture of maternal labour and its complex and troubling relationship with policy.

Infant feeding: A troubled policy terrain?

Despite widely reported health benefits and a national and international policy agenda to increase the uptake and duration of breastfeeding, the U.K. has one of the lowest breastfeeding rates in the developed world (Bolling, 2005; DoH, 2007, 2010; ONS, 2007; WHO, 2003). While both the Department of Health and the World Health Organization recommend that mothers breastfeed exclusively for the first six months, most mothers do not follow this advice and by six months of age only 2% of infants are wholly breastfed and 75% receive no breast milk at all (Bolling et. al., 2007; Hoddinott, et al, 2008; ONS, 2007). In statistical terms then, most babies are formula fed for most of the time by most mothers such that bottle-feeding might be considered ‘normal’. However, interview and survey based research suggest that the majority of mothers plan to breastfeed; feel stigmatized by not breastfeeding

and regret not having breastfed for longer, indicating a troubling gap between mother's reported expectations and experiences in practice (c.f. Dykes, 2005 and Hoddinott et al, 2008).

This theme is much in evidence in the feminist critique of UK breastfeeding policy, which its critics suggest is indicative of a wider 'responsibilising' agenda which has seen an intensification of parenting alongside an erosion of parental autonomy such that matters which were once the private concerns of families have become increasingly contested and politicised (Knaak, 2005; Lee and Bristow, 2009; Lee et al, 2010). As Lee and others argue, the construction of breastfeeding as the only reasonable maternal choice reflects the currency of the idea that parents themselves represent a significant risk to their children's health and a means by which mothers are increasingly measured and measure themselves (Blum, 1999; Knaak, 2010; Kukla, 2008; Marshall et. al., 2007; Murphy, 1999).

However, whilst this argument offers an important critique of the individualist logic of a neo-liberal public health agenda, its restriction to an analysis of policy documents and interviews with mothers before the birth of their babies or when this period is drawing to a close is such that it is limited in the degree to which it can offer an understanding of the ways in which mothers may or may not experience these tensions in the everyday practice of feeding their infants. This is of particular relevance within the context of epidemiological evidence that the most significant decrease in breastfeeding occurs in the first four days following child-birth, suggesting that mother's may encounter particular difficulties establishing breastfeeding during this time (Bolling et. al., 2007; Hoddinott, et al, 2008 ONS, 2007). In policy terms, further tensions are suggested by policy and guidance which tasks midwives, the primary providers of care during this period, with working to a woman-centred agenda whilst also promoting and supporting breastfeeding (Leap, 2009; Page, 2009). This may be illustrated with reference to the Royal College of Midwives (2004:1) breastfeeding position statement which affirms midwives requirements to 'promote informed choice and support women in their chosen method of infant feeding' and in NICE guidance (2006) in which the

importance of information, advice and support for breastfeeding is prioritised alongside an emphasis on woman and baby centred care which recognizes ‘the views, beliefs and values of the woman, her partner and her family.’ However, despite wider feminist interest in mothers ‘complicated relationship with medical institutions and spaces’ (Kukla, 2008:69) the ways in which these policy priorities are mobilised in practice has been little researched.

This chapter addresses this deficit in the literature order to examine the ways in which mothers and midwives talk about and practically manage infant feeding at the level of service delivery. Drawing on researcher-generated video-tapes of midwives’ routine visits to mothers (Lomax, 2005; 2011), the analysis consider the ways in which policy priorities are ‘talked into being’ (Heritage, 1984) and the implication for women’s moral identities. For brevity, the analysis is focused on three visits to three mothers: ‘Megan’, who is successfully breastfeeding her first baby; ‘Emily’, who is experiencing difficulties breastfeeding her second baby and ‘Chloe’, a first time mother who is formula-feeding her daughter. Data, which was transcribed and analysed using a modified form of conversation (c.a) and discursive analysis (d.a.) (Heath et. al., 2010; Reynolds and Taylor, 2005; Wooffitt, 2005) is presented in the form of transcribed sequences in order to make visible the ways in which dominant and residual narratives (e.g. about what constitutes appropriate mothering) are deployed and resisted. A focus on the ‘architecture of talk’ (Heritage, 1984) which encompasses the ways in which turns at talk are allocated; whether they proceed smoothly or dysfluently; display agreement or resistance enables an exploration of the ways in which particular maternal identities are discursively constructed.

Drawing on these examples, the analysis explores the ways in which mothers’ infant feeding choices are discursively sanctioned and how this is made visible through the absence or presence of ‘trouble.’ This includes the ways in which breastfeeding is acknowledged to present both practical and corporeal challenges for mothers (talk is *about* troubles) but more particularly the ways in which midwives’ questions and mothers’ responses generate accounts which are universally positioned vis-à-vis a discourse of ‘breast is best’ and

through which talk *is* troubled. Accordingly, mothers who do not breastfeed or who are contemplating stopping can be seen do a great deal of rhetorical work to present their decisions as legitimate in order to defend against the implicit allegation of a less than ideal ‘choice’. As I shall explore, the degree to which mothers acknowledge or rebuke this charge is apparent in the ways in which talk is visibly dys-fluent or ‘troubled’.

Breast is best? A morally sanctioned maternal identity

The idea that breastfeeding confers a particular identity as a ‘good mother’ is immediately evident in the midwife’s opening remarks in Megan’s consultation (reproduced in figure 8.1¹).

Figure 8.1: Megan: A sanctioned identity

1	M	I don't like to (.) ur: interrupt you when you are
2		feeding so beautifully
		(2.3)
3	C	I was just-I don't-how do you know if he's actually
4		taking anything (in) (.)
5	M	well he certainly looks as if he is he looks so happy
		(0.9)
6		u↑m (.) he's getting colostrum of course at the
		[
7	C	um:
8	M	moment (.) you haven't got gallons
9		there of course but I mean you know
10	C	it does look like it ahahah
11	M	you're going to be a <u>wonderful</u> breast-feeder
12		I mean you're you're doing so brilliantly
13		is this ↑really your first baby
14	C	um::
15	M	I can't believe it ahaha (0.8) how
16		did you get to be so good! ahah
17	C	((smiling)) is it normally-are there
18		normally problems?

Analysis of this sequence which constitutes the first talk between this mother and this midwife, suggests unequivocal support for the mother’s decision to breastfeed. The midwife’s repeated use of positive and enthusiastic descriptions of the baby as ‘look(ing) so happy’ (line 5) and the mother

¹ A summary of transcription notation is contained in the appendices at the end of this chapter.

herself as ‘a wonderful breastfeeder’ (line 11) convey the appropriateness of Megan’s choice and its association with a positive maternal identity. In Megan’s case, the midwife’s construction of her as ‘doing so brilliantly’ is not entirely unproblematic; whilst she may, at this moment, be experiencing few difficulties, her awareness that this may change is evident in her question ‘I was just-I don't-how do you know if he's actually taking anything in’ (lines 3-4) in which she articulates a familiar concern that it is not possible to see the amount a breastfed baby is consuming. The midwife’s response, which includes the assessment that Megan is ‘doing brilliantly’ implies both that she is succeeding at something which is potentially quite difficult whilst simultaneously downplaying the idea that Megan herself might encounter difficulties. However, as a strategy it is only partially successful, the idea that breastfeeding may not be straightforward for all mothers re-emerging moments later in Megan’s question at line 17 (‘is it normally-are there normally problems?’). Of significance is the ways in which Megan phrases her apprehensions as questions (lines 3 and 17) in ways which diminish their importance (‘I was just’) and foreground them as connected to her own ignorance and downplaying their threat to the midwife’s definition of events. In this way, Megan’s talk acknowledges the dominance of a rhetoric in which breastfeeding is constructed as natural and straightforward whilst also making visible the midwife’s rights within the asymmetrical order of interaction to define it as such and to gloss over threats to it.

Breastfeeding as troubling: A deficit maternal identity?

The theme of glossed and silenced troubles is continued in Emily’s encounter with her midwife which begins with Emily’s vivid description of leaking breasts (lines 71-77); a fractious and unhappy baby (lines 3-5) and her efforts to manage these difficulties including her decision to supplement with formula (line 5).

Figure 8.2: Emily: A troubled maternal identity

1	M	Are you-you’re putting her on and she’s
2	M	going on alright is she?
3	C	Yeah she’s going on alright (.) Last night she
4		wouldn’t settle um and I tried to feed and she

5 was getting' in a state so I did make up a bottle
of SMA

6 **M Oh right**

7 C Um and I gave her that

8 **M *That's a shame when you have got all thatahaha***

9 C That's right yeah ((laughter))

10 But um she was getting frustrated and um
((Mother gets up to let dog in))

11 **M yeah**

12 C she had fed a lot of me but then um

66 **M And you know she might feed every two**
67 **hours one day and then she'll gradually sort**
68 **herself out ((inaudible – dog barking))**

69 C Because last night I mean – Whistler ((dog))
70 GO AND LIE DOWN– I
71 um I mean last night I put towels under
72 the sheet because I was actually saturated
73 M ((inaudible – dog barking))

74 C Um and I thought well it ain't getting on the
75 mattress and I thought well if it is going to
76 be like this I was going to give up you know
77 like breastfeeding because I can't you know

78 **M Oh no don't do that!**

In this way Emily's represents her experiences as practically difficult but herself as actively working through solutions. However, analysis of the ways in which her talk is organised, reveal the ways in which she actively constructs her decision to formula feed as predicated not on 'choice'; which might engender a charge of maternal selfishness; but as the only possible action for a baby that 'wouldn't settle' and 'was gettin' in a state'. Moreover, her explanation that formula was only offered *after* only she had breastfed, positions her action as a necessary supplement offered by a mother who is demonstrably committed to breastfeeding but in ways which defend against the 'moral danger' and deficit identity associated with formula-feeding (Murphy, 1999). The midwife's response of 'that's a shame' (quietly delivered and accompanied with mild laughter) displays and makes visible that this is indeed less a than ideal state of affairs which generates further justification by the mother (lines 9-10: 'That's right yeah ((laughter)) But um she was getting frustrated').

The imperative for Emily to justify her decision is evident in the embodied and practical context in which she elaborates her explanation. As the video and transcript reveal, Emily, who has experienced an extended hospital stay following her baby’s admission to special care, is single-handedly struggling to catch up with house-work (there are piles of washing visibly waiting to go in to the machine, her anxiety to work through which threatens to disrupt the visit); she also has a toddler and two large dogs whose noisy presence continually threatens to disrupt the flow of the visit. Physically she is in considerable discomfort. Her breasts leak, she has perineal trauma, untreated cystitis and severe bruising to her thigh caused by the administration of pain relief during labour. However, within the context of breastfeeding ‘advice’, these difficulties appear in themselves to be insufficient to justify her decision. They are barely acknowledged by the midwife who deploys minimal response tokens (Heritage, 1984) (lines 6, ‘oh right’ and line 11 ‘yeh’) which avoid engagement with emotional content of Emily’s speech. Moreover, the suggestion that breastfeeding may necessitate feeding every two hours (line 66) ignores the very evident practical difficulties this will entail in this context. What it does illustrate however is the midwife’s imperative to improve breastfeeding rates and its incompatibility with a wider discourse of woman-centred care

Formula-feeding: Troubling the normal?

This final sequence considers the ways in which Chloe’s decision to formula feed is troubled in her encounter with her midwife. The ensuing talk indicates a wider moral and policy framework within which mothers are called to account for their decisions in ways which can be seen to trouble ‘normal’ decisions to formula feed.

Figure 8.3: Chloe: A stigmatised maternal identity

51	M	Are you feedin’ her?(.) yourself breastfeeding	
			[]
52	C		no
53	M	bottle-feeding yes	
		[]	
54	C	bottle-feeding yes	
55	M	right	

(1.2)

56 M **that's what you planned to do was it?**

57 C yes
[

58 M **yeah^**

59 C It's never really appealed to me

60 M **^Fair enough^ she'll survive alright love**

61 C /That's it/ She's doin' fine

62 M **and what you given' her SMA? Cow and Gate?**
[]

63 C oyster *is it oyster?*

64 M **Oster-**

65 C -Oster?

66 M **yeah**

(1.5) ((smiling at baby))

67 M **She's lovely**

(.)

68 M **I'll leave he asleep for a bit ...**

This is immediately evident in the midwife's opening question which assumes that Chloe is breastfeeding (Line 51: 'are you feedin' her?') and which generates a potentially embarrassing pause and clarification (the tag 'yourself breastfeeding'). Further difficulty is generated by Chloe's 'no' which, as the c.a. literature elaborates, is 'dis-preferred' in the normative order of conversation. While speakers usually organise questions in ways which elicit agreement and social cohesion (Hutchby and Wooffitt, 1998) talk in this sequence becomes rapidly and noticeably troubled, marked by pauses and overlaps in which the mother negates to take her turn at talk (lines 55-56; 66-67 and 67-68) in ways which are non-typical and signal increasing disengagement. Chloe's refusal to take her turn at talk necessitates the midwife taking additional turns (e.g. at line 56 'is that what you planned to do was it?') which generate further difficulty, requiring Chloe to reveal that breastfeeding 'never really appealed' which, in the context of a policy and popular discourse in which good mothers are positioned as acting in the best interests of their children, is fragile at best. It also generates some difficulty for the midwife who in this context is unlikely to sanction such a 'choice'. Her discomfort is evident in the way in which she articulates her response; as a high pitch 'squeak' and in which the consequences of this choice for the baby is that she will 'survive'. The mother's response ('that's it she's doin' fine') upgrades the midwife's description of her daughter's well-being while it's

production (rapidly uttered, with an emphasis on ‘fine’) indicates subtle disagreement with the midwife’s assessment (Pomerantz, 1984).

Discussion and concluding remarks

Analysis of these sequences make visible the ways in which breastfeeding provides a morally sanctioned identity for mothers in ways which can be seen to trouble mothers ‘normal’ infant feeding practices. As the data reveal, mothers experience breastfeeding as practically and physically difficult, troubles which are exacerbated by the alignment of breastfeeding with a policy agenda in which it is positioned as the embodiment of good mothering. Midwives construction of breastfeeding as a positive expression of maternal identity appears to gloss over mothers embodied experiences such that mothers who are breastfeeding and/or experiencing problems breastfeeding have difficulty giving voice to their experiences. In contrast, mothers who choose not to breastfeed struggle to construct a positive maternal identity and moreover are subject to a particular form of surveillance as they are called to account for their decisions. These analyses suggest that professional-parent interactions are an important place to explore the ways in which ordinary family practices are framed and troubled by policy agendas and their mobilisation. Analysis of the ways in which mothers position themselves and resist a political and professional hegemony of ideal mothering demonstrate that mothers are acutely attentive to and troubled by a policy rhetoric of ideal mothering which negates the rich texture of their labours.

Appendices: Transcription notation

<u>Symbol</u>	<u>Explanation</u>
M	Midwife
C	Mother
[]	Overlap in speakers’ talk
(0.5)	Pause in speech, in this case of 0.5 seconds
(.)	Pause of less than one tenth of a second
<u>word</u>	Speaker’s <u>stress</u> on a word or phrase
SHOUT	Word or phrase spoken much louder than surrounding text
/ <u>That’s it</u> /	Word or phrase spoken more rapidly than surrounding text
^Fair enough^	Word or phrase spoken at higher pitch than surrounding text
word	Word or phrase spoken more quietly than surrounding text

(word)	Transcriber's uncertainty about what was said
wo::rd	Extension of the sound preceding the colon (the more colons the longer the sound.
word↑	A rise in intonation occurring in the sound preceding the symbol.
((raises head))	Contains transcriber's description

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