

## Breastfeeding and Constraints on Mothers' Agency

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*Breastfeeding is alternately celebrated and rejected because of its intimate identification of mother and child. Breastfeeding advocates insist that the physical closeness produced is advantageous for the health and well-being of both mother and child, while many feminists fear that this closeness will increase gendered inequalities in the home and work place. However, discussions of breastfeeding too often focus on women's "choice" without adequately recognizing that women's choices about infant feeding are constrained by powerful political and moral norms. In this paper I explore the challenges and opportunities breastfeeding presents to our understanding of individual agency. I begin by discussing how current discourses of breastfeeding constrain women. Despite efforts in breastfeeding promotion to convince women to "choose" to breastfeed, without adequate material and social support women do not actually have the ability to choose. At the end of this paper I turn to Irigaray to illustrate alternative ways of understanding agency that simultaneously value independence and connection with others. Taking breastfeeding seriously requires that we change how we understand the relationship between individual freedom and connection to others. This will also involve recognizing the embodied and gendered nature of breastfeeding.*

### Definitions of Agency

The superiority of breast milk for infant health has resulted in enormous pressure upon mothers to breastfeed or risk being accused of jeopardizing their child's health. However, breastfeeding has been constructed as a "choice" in a way that obscures the complex array of social forces to which women are subject. I will therefore discuss how agency is understood in the theoretical literature before

going on to discuss how breastfeeding as it is currently practiced constrains women's agency.

Susan Sherwin distinguishes between agency and autonomy, arguing that women often demonstrate agency by making choices regarding their health care, but she rejects the view that active choosing in and of itself constitutes autonomy (Sherwin and Network 12). Sherwin uses the term agency to describe informed choice, while reserving the term autonomy to refer to a more comprehensive notion of freedom, where not only is the immediate choice uncoerced but the circumstances that structure that choice are also free of the coercive dimension of oppression (Sherwin and Network 12). Autonomy refers to "internal control" or "self-governance" and is etymologically derived from one the root *auto* (self) and *nomos* (law). Catriona Mackenzie describes bodily autonomy as not having one's body or personal space intruded upon, either directly or indirectly, without one's consent (421). She argues that autonomy requires that the individual decides what happens to and with her body (Mackenzie 420). Obviously this definition of autonomy is incompatible with breastfeeding's physical closeness and responsiveness to a child. Agency is a less robust concept than autonomy and manifests as self-definition or self-direction. Agency is often understood as freely choosing one's own actions against the backdrop of various social forces. However, Sue Campbell notes that little attention has been paid to how agency fits together with embodiment (Campbell and Meynell). Breastfeeding demands that we recognize that choices are not made in isolation from bodily realities.

### **How Breastfeeding Constrains Mothers' Agency**

Breastfeeding requires intensive time and labour, can extend over months or even years, curtails women's movements (especially outside the home), and potentially conflicts with employment. Consequently, breastfeeding presents challenges to women's independence and personal liberty. Mothers are assigned the responsibility for their children's preventative health care, and breastfeeding is required in order to minimize risk. The same techniques of the self that have been applied to pregnancy have been extended to breastfeeding. Women are discouraged from consuming alcohol, tobacco and drugs and encouraged to maintain a healthy diet. Despite the common description of breast milk as a pure and healthy food, this is nonetheless dependent on the proper self-management of the maternal body. The female subject is displaced by an emphasis on the health and well-being of the infant, resulting in an expanding list of self-regulatory behaviour for women to abide by.

Mothers have been stripped of their roles as expert through the medicalization of childbirth and childrearing. They are treated as passive recipients of expert

medical knowledge, while at the same time intense responsibility is imposed upon mothers to make optimal infant feeding decisions. Maternalist breastfeeding advocacy reinforces gender stereotypes in arguing that caring is part of women's "nature." On the one hand women are treated as less autonomous, less capable, and therefore requiring the advice of experts; while on the other hand, the ideology of the "good mother" holds women to increasingly high standards of intensive mothering in isolation from social supports.

The challenge breastfeeding poses to women's freedom was recognized early on by feminists. For instance, Simone de Beauvoir criticized both pregnancy and breastfeeding because these activities prevent women from realizing their own projects. De Beauvoir describes how, for some women at least, the infant "seems to be sucking out her strength, her life, her happiness. It inflicts a harsh slavery upon her and it is no longer a part of her: it seems a tyrant; she feels hostile to this little stranger, this individual who menaces her flesh, her freedom, her whole ego" (Beauvoir 508). The dependence of the fetus and infant restricts the free movement of a woman; therefore de Beauvoir argued that pregnancy, birthing and breastfeeding are not processes that individuals can engage in without relinquishing their autonomy.

Breastfeeding continues to be viewed by some feminists as a challenge to women's freedom because it requires ongoing responsiveness to an infant and restricts mobility. Rebecca Kukla argues that breastfeeding necessarily conflicts with women's autonomy. She asserts that "A woman who feels that she cannot leave her infant, or even reasonably deny her infant any form of access to her body, cannot do the concrete things that normal humans need to do in order to have a meaningful, distinct identity that is comprehensible to themselves and others" (2005: 178). Women often experience ambivalence at giving up some of their personal autonomy in being tethered to a nursing infant. May Friedman describes some of the ways in which the goals of feminism (that is, to de-rigidify gender roles and reconstruct parenting as a work that both sexes share equally) may conflict with the deeply gendered and therefore unequally shared activity of breastfeeding, at the expense of maternal agency (Friedman).

Linda Blum suggests that both a maternalist and medical model of breastfeeding have developed in Western culture (Blum). Having assumed authority over infant feeding, Western medicine now strongly encourages women to breastfeed because of the nutritional superiority of breastmilk over infant formula. Maternalist championing of breastfeeding values the process of breastfeeding because it connects infant and mother in a unique bond, while assuming that women will find this physical intimacy fulfilling (the La Leche League is a hugely influential example). Maternalist support for breastfeeding takes for granted that women are naturally well-suited to

nourish children. Although maternalism values women's caring roles, like western medicine it has also focused primarily on the benefits breastfeeding provides for infants. Glenda Wall concludes that both the maternalist and medical models of breastfeeding render the mother as subject with legitimate needs and wants invisible (Wall 604). Women as breastfeeding subjects disappear as their behaviour becomes subject to public scrutiny and external moral authority.

Breastfeeding promotion efforts constantly emphasize the individual responsibility women have to breastfeed their children. Wolf and Kukla, in their analyses of breastfeeding promotion campaigns, note the extent to which mothers are constructed as most responsible for the health and well-being of their children (Wolf; Kukla 2006). Although the natural motherhood movement began by contesting the medicalization of childbirth, nevertheless maternalist organizations such as the La Leche League have turned breastfeeding and intensive mothering into moral imperatives and likewise construct mothers as being primarily or even solely responsible for the health and well-being of their children. At the same time, both the medical and maternalist models enforce reliance on expert advice as an essential part of good mothering practice. Women are at the same time treated as fully responsible for the health of their children and as completely reliant on experts in order to determine appropriate techniques for caring for them.

The bottle-feeding culture, public disapproval of exposed breasts, the lack of training medical professionals receive in how to support breastfeeding, and the difficulties faced in combining breastfeeding with work outside the home, all undermine the capacity of women to breastfeed. But although social and material constraints erode women's agency in infant feeding decisions, this is not recognized in health promotion policies that attempt to increase breastfeeding initiation and duration. Rather, individual women are the target of campaigns that assume women lack knowledge about the benefits of breastfeeding or are resistant to breastfeeding for selfish reasons. Despite the fact that incompatibility with work is a leading reason women stop breastfeeding, combining work and breastfeeding is made the responsibility of individual women (and in maternalist discourses work is often described in terms of women's selfishness). As Stephanie Knaak points out, the structure of infant feeding choice has become one of "non-choice" because of the rigidity of expert advice women now receive (Knaak). Breastfeeding advocacy focuses on providing advice to women without recognizing the social circumstances that make breastfeeding difficult or even impossible. Kukla (2006) notes that current breastfeeding advocacy campaigns are likely to decrease women's agency in making infant feeding decisions. The constant emphasis on educating women about the benefits of breastfeeding (or the risks of formula feeding)

fails to recognize that women are already aware of the health advantages of breast milk (Guttman and Zimmerman). Public health campaigns advocating breastfeeding view women as recalcitrant due to lack of knowledge, but this assumption is not supported by research; rather, as Kukla (2006) points out, low breastfeeding rates is falsely taken as proof that women are ignorant of breastfeeding's benefits. In fact, the leading reasons women do not breastfeed are not due to lack of knowledge but rather because of the very real material and social impediments to breastfeeding including inadequate maternal leaves, lack of safe space to breastfeed in (both at home and at work), disapproval of breastfeeding by other family members, and unhelpful advice from medical professionals. Discomfort with breastfeeding in public has also been identified as a contributing factor in shaping infant feeding choice and the decision to stop breastfeeding in particular (Boyer 430). The reasons women fail to breastfeed are not linked to irrationality or lack of understanding on the part of mothers about the benefit of breastfeeding. Nor are they linked to a lack of concern among mothers for their babies' well-being (Carter 206). There are structural and cultural factors that limit the choices women have when it comes to caring for their children. Here, as in other areas of childrearing, the emphasis is on maternal responsibility while taking for granted a cultural model of natural, intensive, self-sacrificing and isolated motherhood.

Discussions of the costs and benefits of breastfeeding usually focus on the benefits to children, and consequently, the social benefits of lower health care costs. It is assumed that women will benefit from what is good for their infants or that they will experience a close and intimate relationship to their infant as rewarding. When benefits to women are discussed, it is normally mentioned that breastfeeding will help women lose weight and return to their pre-pregnancy body. However, this plays into insecurities about the attractiveness of the maternal body and reinforces cultural conceptions of the proper female body shape. Although the many benefits of breastfeeding are socialized (which is why breastfeeding promotion remains a target of many public health campaigns), the costs remain individualized and are disproportionately borne by women in the form of higher grocery bills for healthy food (and larger quantities of it) and potentially negative career consequences, not to mention the time and energy required to breastfeed. Breastfeeding comes at a cost: if a woman is not adequately nourished, breastmilk depletes the store of nutrients in her body. Although the precise amount of energy required for sustaining lactation continues to be debated, approximately an extra 400-500 calories beyond what is needed to maintain the mother's body weight is required (Riordan 438). If the mother does not eat high quality, nutritious food, it is more likely to negatively affect her own health than that of her child. The additional energy required to breastfeed has an economic cost as well. Although the Toronto

Nutritious Food Basket average cost for a woman between the ages of 14 and 50 is \$38.91 per week, for a breastfeeding woman it costs on average \$44.92 per week, an increase of 15.4 percent (Toronto Public Health; Ministry of Health Promotion).

There are many impediments to breastfeeding including race, youth, low socioeconomic status, history of sexual abuse, and negative body image. White, middle-class, highly-educated, heterosexually partnered, and older mothers are more likely to initiate breastfeeding, and achieve exclusive breastfeeding (Ahluwalia et al.; Ryan, Wenjun and Acosta). Breastfeeding rates are very low among many other groups of women (Hausman 2003: 489). In addition to financial constraints, there are other social factors that prevent racialized and poor women from breastfeeding. Compared to middle class white mothers they are perceived as being highly sexualized and suspicion is raised as to whether or not they are “fit” mothers. Bernice Hausman notes that black mothers “are represented publicly as being quite capable, all on their own, of negligently causing the death of their infants, while white women are portrayed as inherently well-meaning and thus needing to be misled by experts in order to inflict the same damage” (2007: 485). While white middle and upper class women internalize the demand for “perfecting” children, more vulnerable women including low-income, racialized, unmarried and younger mothers are more likely to be supervised in their infant feeding practices and experience scrutiny as an external coercive force (2007: 485). Breastfeeding thus poses questions of social justice. If white women and women of higher socioeconomic status are more likely to breastfeed, breastfeeding could be considered a class-based and race-based privilege rather than a viable infant-feeding decision. The health benefits of breastfeeding will not be distributed equally to all infants (McCarter-Spaulling 489).

The dominant discourses of breastfeeding, which demand that women seek out and follow expert advice, prevent women from exercising autonomy in feeding their children. Until breastfeeding receives significant increases in material and social supports, autonomy will not be possible in infant feeding. Women’s autonomy in choosing how to feed their children is constrained by the dominant medical and maternalist discourses regarding breastfeeding, both of which pay insufficient attention to the material and social conditions required for breastfeeding. There is inadequate support for breastfeeding, and because of the way breastfeeding is presented as the best choice for children women do not properly speaking have a “choice.” Women’s choices are limited by material and social constraints as well as circumscribed by discourses of power that categorize women as either “good” mothers or deviants in need of education and assistance depending on how they feed their children (Stearns; Murphy).

## An Irigarayan Model of Agency and Autonomy

Many feminists criticize the individualistic conception of autonomy as inherently masculinist because it assumes that it is both possible and desirable to live independently of others, an assumption that is quickly disproven by women's experiences of caring for others. Bernice Hausman argues that the ideal of autonomous adulthood is inherently sexist because it specifically excludes women from public life (2007: 496). Current understandings of agency as individualistic and free of physical attachment to others can serve to undermine breastfeeding; Sarah Earle found that some mothers turn to formula feeding in an effort to re-establish their identities prior to motherhood as separate individuals.

Blum argues that infant feeding can serve as a site for working out paradoxes of female autonomy and argues that breastfeeding actually has the potential for resisting gendered inequalities. Breastfeeding provokes ambivalence because it restricts women's freedom, but this ambivalence can also point the way to an expanded understanding of individual agency as compatible with caring for children.

I now turn to the work of Luce Irigaray because she makes sexual difference the foundation of her psychoanalytic feminist theory thereby providing a way of getting beyond some of the problems I have discussed above. Irigaray (2000) critiques liberal philosophy's aim to provide equal access to power, arguing that it can only articulate this in terms that are sexually neutral. Because the public sphere has traditionally been almost entirely male-dominated, it evolved under the assumption that occupants have a male body (Gatens 124). Women can achieve the norm or standard of the liberal individual only insofar as they either deny their own corporeality or manage to juggle their traditional role in the private sphere and their new "equality" in the public sphere. Irigaray argues that this gap between sexually differing individuals allows for the autonomy that is necessary for ethical relations in society. In order to recognize sexual difference, both women and men must have freedom and separation (Irigaray 1993). Irigaray (2004) understands autonomy as attaining self-determination and respect, and this goal requires the protection of civil law. Thus, Irigaray calls for a much more radical transformation of society in order to establish women's autonomy. In the case of breastfeeding, specific rights protecting breastfeeding and guaranteeing women the material support and protections required to carry it out would need to be enshrined in civil law.

While Irigaray writes more explicitly about autonomy than agency, nevertheless her writings provide various political strategies for resisting oppression. Some of these strategies are negative—that is, they react against existing discourses of power—and others are positive—they involve women creating new possibilities for how to live (Rozmarin). Developing breastfeed-



ing agency requires both of these strategies, since we need to both critically engage with existing power discourses as well as create new ways of living and breastfeeding. Although dominant discourses around breastfeeding insist on the importance of women's choice, I have explored how in fact women's choices are constrained in many ways. I follow Irigaray in arguing that autonomy requires both separation and connection with others. It also requires recognizing sexual difference and women's embodiment in order to develop ways of living that allow women to freely decide for themselves how they wish to feed their children. Autonomy remains for Irigaray a goal to be striven towards rather than something currently possible. As long as we have a defective understanding of agency and autonomy the false "choice" of how to feed children will continue to evoke ambivalence, guilt and shame in women (Friedman). However, through recognizing autonomy as a goal for motivating changes in our understanding of breastfeeding, and employing various positive and negative strategies for increasing agency in child feeding practices, we can move towards increased possibilities for women to develop their own definitions of successful motherhood. Critiquing existing discourses of breastfeeding and providing more material and social support for breastfeeding will help make the practice more comfortable and more compatible with a strong and healthy self-image for more women.

Despite evidence that women are well aware of the advantages of breastfeeding, this knowledge has not translated into changes in behaviour and breastfeeding rates have plateaued. The focus on women's choice treats agency as disembodied and isolated from material and social reality. Drawing on Irigaray, we can understand individual agency as embodied and sexual rather than universal and abstract. Current breastfeeding promotion efforts do not have an appropriate recognition of the social and material constraints on mothers that include food insecurity, lack of safe spaces to breastfeed in, social disapproval of breastfeeding, lack of accommodation of breastfeeding in workplaces, and the effects of racialization and socioeconomic differences. Supporting women's agency requires recognizing the ways in which breastfeeding practices are constrained and working towards providing the necessary material and social supports. It also requires that we stop moralizing about breastfeeding and constructing breastfeeding as the only way to be a good mother. Breastfeeding promotion efforts need to stop focusing on educating women and warning them of the risks of not breastfeeding. Promotion efforts need to recognize that women already care deeply about the health of their children and are aware of the benefits of breastfeeding. Invoking guilt in women does not increase their agency. Instead, promoting breastfeeding must be redefined as promoting the social and economic structures that make it possible for women to breastfeed. Rather than eroding women's agency,



broad efforts must be made to support and develop it in order to promote the health and well-being of both mothers and children.

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