CROSS-CULTURAL FRAMING STRATEGIES OF THE BREASTFEEDING MOVEMENT AND MOTHERS' RESPONSES

By

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CHAPTER I

INTRODUCTION

Research establishes breastfeeding as the medical gold standard for infant feeding (Knaak 2005). Yet, even though current medical arguments favor breastfeeding for children, its use and duration among U.S. and Canadian mothers is significantly lower than the governments' goal rates. To increase breastfeeding initiation and duration rates, medical, state, and other organizational actors have coordinated their breastfeeding activism into a social movement, the goal of which is to increase these rates. Activists do this, in large part, by constructing breastfeeding outcomes as desirable and formula feeding outcomes as risky. Examining this movement and responses from the intended targets of this activism provides rich data that speaks to a variety of sociological literatures.

First of all, breastfeeding activism provides an excellent opportunity for researchers to examine the strategic tactics of social movement organizations. Because the goal of breastfeeding activism is to increase the initiation and duration rates of breastfeeding, the desired outcomes directly relate to *embodied* experiences; in this case, the bodily experiences of mothers and infants. Researchers are only recently beginning to explore the unique strategies of social movements that focus on embodied experiences (Brown and Zavestoski 2004; Brown, Zavestoski, McCormick, Mayer, Morello-Frosch, and Altman 2004; Hess, Breyman, Campbell, and Martin 2008; Zavestoski, Morello-Frosch, Brown, Mayer, McCormick, and Altman 2004). They have found that activists in

these movements are unique in their ability to make biological bodies central to their work, using them to simultaneously draw on and contest medical authority regarding their embodied complaints. Scholars are interested in both the strategic use of the body in social movement activism as well as developing a better understanding how movement activists work with and against medical targets at the same time (Brown et al. 2004; Hess et al. 2008; Morello-Frosch, Zavestoski, Brown, Altman, McCormick, Mayer 2005).

In addition to the interesting alliances being formed between lay breastfeeding activists and medical practitioners, these activists have also developed a strategic coalition with government organizations. Therefore, the breastfeeding movement is composed of lay, medical and government activists all working together to increase breastfeeding initiation and duration rates. This combination of such a variety of voices allows researchers to examine the understudied phenomenon of frame variation within a movement (McCammon 2009; Snow, Vliegenthart, and Corrigall-Brown 2007). Each of the organizations participating in breastfeeding activism is likely to approach their work from their own unique perspective, especially since sometimes the groups are working against each other. For example, lay activists will work with medical activists and draw on their authority to make claims regarding the benefits of breastfeeding. However, they may also be working to challenge medical research that argues formula is a suitable substitute for breast milk. Thus, this movement allows researchers to compare and contrast how different organizations construct their persuasive arguments while ultimately working towards the same goal.

Thirdly, breastfeeding activism is taking place on an international level, which presents researchers with an opportunity for a cross-cultural study. For example,

breastfeeding activists have campaigned for an increase in breastfeeding rates in both the United States and Canada during a similar period of time with different outcomes. Therefore, studying this movement allows researchers to compare how cultural context affects the strategies and tactics used by activists in the same movement but in different geographical locations. Such an examination could be a response to the call for more cross-cultural research, particularly in the area of social movements (Benford 1997).

In addition to investigating the macro-level construction of breastfeeding, studying this movement allows researchers to examine how the intended targets of this activism—mothers—respond to the dominant discourse that is being established. Such research can explicate the ways in which mothers' own constructions of infant feeding intersect with, challenge, or reaffirm the discourses presented by the movement. This research contributes to scholarship regarding the nature of power that exists between macro-level discourses and the micro-experiences (Foucault 1977). Furthermore, by examining how breastfeeding is bound up in ideologies of "good" motherhood, this research contributes to feminist literatures on the experiences of mothers (c.f., Apple 1995; Blum 1999; Hays 1996; Tapias 2006; Wall 2001). For instance, it expands our understanding of "intensive motherhood," a belief system that demands that mothers provide unlimited amounts of care, attention and affection to their children (Hays 1996), as we see how breastfeeding fits in with these demands of "good" motherhood.

Finally, like the activism, women's reactions to breastfeeding discourses are occurring cross-culturally. In fact, we know that mothers in Canada are more likely to breastfeed than mothers in the United States (see Figure 2.1), and examining how these women compare in their constructions of infant feeding may shed light on reasons for this

difference. Therefore, in addition to expanding the general understanding of women's experiences as mothers, this research gives opportunity for an analysis of the ways in which cultural context affects the lived-experiences of motherhood.

For this dissertation, I address each of these issues as I examine the cross-cultural framing strategies of breastfeeding activists and the micro-level responses to this dominant discourse.

Guiding Research Questions

This project is an inductive inquiry into the relationship between macro-level breastfeeding activism and the ways in which messages promulgated by breastfeeding activists affect how the intended recipients—mothers—construct infant feeding in their own lives. This research was guided by two groups of research questions, each addressing one phase of data analysis.

The first set of questions addresses the macro-level discourses of the breastfeeding movement. First, what kinds of arguments are used to persuade women to breastfeed? How do the strategies used in the breastfeeding movement compare between activists in the United States and Canada, particularly in light of higher breastfeeding rates in Canada? How do typically antagonistic organizations—lay activists strategically working with government and medical organizations—unite to promote the same goal: to increase breastfeeding rates? Finally, how do these different organizations compare in their argumentative strategies?

The second collection of questions concerns the micro-level responses to these discursive constructions. How do mothers, the intended targets of these organized messages, construct infant feeding? Do women in the U.S. understand breastfeeding differently than those in Canada? Are the movement's macro-level discourses evident in the ways in which mothers construct their own understanding of infant feeding? Do the ways in which the breastfeeding movement constructs "risk" around formula feeding affect women's beliefs and decisions about breast versus formula feeding their own children? These questions guide the following research.

Contributions to the Existing Body of Literature

This dissertation employs a multi-level analysis to straddle several gaps in a range of existing literatures. To begin, this research addresses the burgeoning scholarly attention paid to the framing activity of social movements (Benford and Snow 2000; Snow 2004). In particular, I contribute to the dearth of scholarship on "frame variation" (McCammon 2009; Snow et al. 2007) by examining variety in framing strategies across cultures—including activists in the United States and in Canada, as well as across organizations—including how lay, government, and medical activists differ in their framing. Such a multi-layered approach to framing within the same movement is certainly needed in the framing literature in order to better understand how activists working towards the same goal differently construct their persuasive arguments (McCammon 2009; Snow et al. 2007). These findings are especially important given that many breastfeeding activist organizations simultaneously ally with and contest against other organizations participating in the same movement.

Secondly, this study contributes to an emerging interest in embodied health social movements. Scholars are examining how activists use "embodiment" in their framing activities and how they use "strategic coalitions" to increase their medical authority (Brown et al. 2004; Brown and Zavestoski 2004; Hess et al. 2008; and Zavestoski et al. 2004). This project examines how breastfeeding activism functions as an embodied health movement, as activists use the personified threat of illness for mothers and children in order to persuade mothers to breastfeed rather than formula feed their children. Furthermore, I investigate how a variety of organizations simultaneously contest and ally themselves with each other in their efforts to make a compelling case to breastfeed.

Thirdly, I contribute to feminist knowledge on the experience of motherhood and breastfeeding (Apple 1995; Blum 1999; Hays 1996; Knaak 2005; Schmeid and Lupton 2001; Stearns 1999; Tapias 2006; Wall 2001). I connect the macro-level activist discourses with the micro-experiences of the intended recipients of these messages. In this case, I examine whether or not the way that mothers in the United States and Canada construct their understanding of infant feeding intersects with, reaffirms, or contests the dominant discourses established by the breastfeeding movement. Such research not only provides cross-cultural insight into women's experience as mothers but also how they experience being targets of persuasive mothering messages and ideologies.

Outline of Dissertation Chapters

This dissertation comprises five chapters, each of which addresses a separate facet of the study. These chapters are unified through the overarching themes of the

construction of infant feeding and the relationship between macro-level discourses and the lived experiences of the targets of those potentially persuasive messages.

Chapter Two presents both the theoretical foundations of this research project as well as the data and methods used in these analyses. This chapter presents three kinds of scholarly literature to which this research contributes. First of all, I argue that breastfeeding activism is best understood as an embodied health movement and I present gaps in contemporary framing theory to which this analysis contributes. Secondly, this research enhances our understanding of risk construction in contemporary societies, particularly as a biopolitical effort by the government to influence and control people's health beliefs and behaviors. Thirdly, I contribute to research on breastfeeding discourses and experiences, as well as feminist analyses of motherhood in general. In Chapter Two, I outline these three theoretical foundations and explain how my research project expands our knowledge in these areas. Also in Chapter Two, I present the data and methods used in this study. I gathered data for this research using two qualitative methods, including a cross-cultural content analysis of activist literature and in-depth interviews with mothers in Nashville and Toronto. In Chapter Two, I outline these methods as they are used in this study and detail the sampling methods and the resultant dataset from which the conclusions of this dissertation are drawn.

Chapter Three addresses the framing strategies used by breastfeeding activists. I begin by outlining the framing strategies used by activists and how these framing strategies "do" embodiment and boundary work. Then, I begin examining frame variation across different organizational types and geographical locations. I start "at the top" and look at the differences in framing strategies used by activists in Canada and the

United States. Next, I compare how lay, government, and medical activists are similar or different in the arguments they use to persuade mothers to breastfeed their children. Finally, I look at the intersection of inter-organizational and cross-cultural differences in framing strategies. In this analysis, I draw on a variety of theories to explain framing differences, including discursive opportunities, strategic coalitions, and cultural contexts.

Chapter Four discusses mothers' own conceptions of infant feeding. I look at how mothers draw on the discourse of intensive motherhood in their conception of "good" parenting and how the pressure to breastfeed fits into that mothering ideology. In this chapter, I also examine the complexity of how mothers' lived experiences may or may not match up with their ideological expectations, and the ways in which they revise their ideologies in these circumstances. Additionally, I compare how mothers differ in their interpretations of motherhood and breastfeeding, particularly in light of being from either the United States or Canada.

The remaining fifth chapter concludes the study with a review of important findings of the dissertation. Chapter Five also highlights the various contributions this dissertation makes to framing theory, health social movements literature, and feminist theory on motherhood. I explore possible avenues for related future research as well as how the findings from this study are likely to apply to other cases of investigation. Finally, I conclude with a discussion of the policy implications for the findings in this project.

CHAPTER II

THEORY AND METHODS

History and Theoretical Background

In the first part of this chapter, I outline the theoretical backdrop for this project and articulate the importance of this research inquiry. I begin with the historical development of breastfeeding activism as a social movement. Secondly, I specifically outline the ways in which contemporary breastfeeding activism constitutes an embodied health social movement. Next, I provide an overview of the social movement framing literature. I first explicate some key words and concepts (e.g., what a frame is) and then examine the unique kinds of framing seen in embodied health movements. I also consider how activist framing contributes to a culture of risk around infant feeding, subsequently affecting women's experience of motherhood. Furthermore, I outline the literature regarding the power exercised in these kinds of discourses. Such efforts to control women's health beliefs and behaviors regarding infant feeding are considered to be examples of "biopower" being exerted by the government. Finally, I present an overview of contemporary research on breastfeeding discourses.

I. Breastfeeding as a Social Movement

Here I outline some of the critical points in the development of breastfeeding activism into a social movement.[1] I begin with a brief discussion of the history of breastfeeding activism in the U.S. and Canada. Next, I examine the cultural context for breastfeeding activism that led to the development of an organized social movement. Finally, I expound upon the definition of social movements and defend how breastfeeding activism fits into this paradigm.

History of Breastfeeding Activism

As Blum (1999) and others (c.f., Van Esterick 1989 and Apple 1987) point out, there has almost always been a push for mothers to breastfeed (rather than feed cow's milk in the earlier years and formula in the later years) in North America. Because "infant-feeding decisions directly affected infant mortality rates, and, through this, the demographic structure and long-run viability of societies; such 'private' decisions were, therefore, thoroughly public" (Blum 1999:20). Governments and other state actors felt compelled to make recommendations about infant feeding practices for the sustainability of an efficient community. Blum (1999) explains that this:

> prescriptive advice extends from the colonial days, when nursing was a mother's sacred duty, through the eighteenth and nineteenth centuries, when it was considered a mother's civic duty to the growing republic, and finally, to the twentieth-century public health campaigns that portray nursing as her contribution to U.S. global dominance. (p. 19)

Both the U.S. and Canadian governments became increasingly involved in breastfeeding campaigns during the early twentieth century. While working to overcome perceived

[1] See Blum (1999) for a more complete history of U.S. breastfeeding activism, particularly focusing on breastfeeding as a class- and status-enhancing project.

threats to domestic power by increased immigration, this period, from the early 1900s to the 1930s, began the state's interest in *legislating* their control over the maternal body, rather than simply providing "expert" recommendations. These "baby-saving" campaigns focused on policies of "race betterment" and efforts to assimilate nonwhites to accept and participate in American middle-class norms, which included breastfeeding.

Women of the period, 1900-1930, were also drawn to this activism, adopting a "maternalist" perspective as a means to abate social ills. Koven and Michel (1993) argue that "rather than claiming to be equal citizens with men, they [maternalists] used the rhetoric of gender difference, invoking women's motherly virtues, to gain a distinct voice as the defenders of children" (p. 23). Both maternalists and public health activists used breastfeeding as a major component in these "baby-saving" campaigns, arguing that motherhood could only remain sacred without the "unnatural" intrusion of artificial feeding and holding mothers entirely accountable for children's health and welfare (Blum 1999).

The time between the 1930s and the 1970s served as an anomalous period in which the cultural push switched from a maternalist concern for breastfeeding to a medical focus on formula feeding. This shift followed a more general push towards an increase in medical authority and medicalization of the maternal body. In their efforts to curtail infant deaths and to seize the lucrative opportunity for more business, physicians began to supervise maternal care and infant feeding, so much so that hospital birthing, rather than home birthing, became the accepted norm (Blum 1999). Medical doctors increasingly mistrusted the maternal body and encouraged women to formula feed their children as a safety measure against uncontrollable and unknowable human nature.

Furthermore, hospitals, largely funded by formula corporations through pediatric grant research, "sabotaged breastfeeding: they relied on strict feeding schedules, separated mothers and babies for long intervals, and regularly gave supplemental bottles" (Blum 1999:30). The end of this period marks some of the lowest breastfeeding rates in U.S. and Canadian history.

In the 1950s, a bit of maternalism began to resurface in the forms of female and maternal support groups. Generally Christian-based, these groups sought to strengthen families and promoted "natural" childbirth and breastfeeding as a spiritual connection between mother and child. These women were drawn to communal mother-to-mother support as a form of empowerment. The most well known group that emerged at this time is the La Leche League (LLL), a group that, like the early maternalists, used "women's gender difference and motherly authority" in their philosophy to "speak for the baby" (Blum 1999:37). A main argument of LLL describes "good" mothering as achieved through breastfeeding.

By the 1970s, second-wave feminists also began working for breastfeeding as part of the women's health movement (WHM). The goal of the WHM was to "wrest control of [women's] health and bodies from (male) medical professionals, challenge the orthodoxy of the medical establishment and develop a way of understanding the body that was based on the feminine qualities of self-awareness and body consciousness" (Moore 2008:270). The central arguments of the women's health movement included a resistance to medicalization, a conceptualization of medicine as a form of social control, and a demand for more equality in the treatment and diagnosis of women's illnesses. Similar to the LLL maternalists, women's health activists advocated a "back to nature"

approach to motherhood including natural childbirth and breastfeeding as a means to reject medical (read male) intervention in and control of their bodies. Blum (1999) writes that "[b]reastfeeding, in particular, was viewed through this social movement lens, as a 1970 *Newsweek* article announced: 'the *hippies* seem to be in the forefront of a back-to-the-breast movement'" (Blum's emphasis, p. 44). Such began women's involvement in contemporary breastfeeding activism.

The activist efforts of the maternalists and "hippies" of the 1970s were joined with church- and university-based organizations that challenged the corrupt practices of formula companies in the Third World. Contemporary versions of these groups include the International Baby Food Action Network (IBFAN) and Infant Formula Action Coalition (INFACT), which developed strategic campaigns against formula promotion in underdeveloped nations. These activists argued that the marketing of formula in these poor countries led to unnecessary health problems and the deaths of infants, often due to a shortage of clean water with which to mix the formula. The most notable strategies of these groups included a ten-year (1974-1984) global boycott against the formula company Nestlé. These activities signaled the beginning of an organized movement consisting of multiple actors (i.e., maternalists, feminists, and anti-corporate activists) using a variety of strategies and arguments working for a common goal—the vigorous promotion of breastfeeding as the ultimate form of infant feeding.

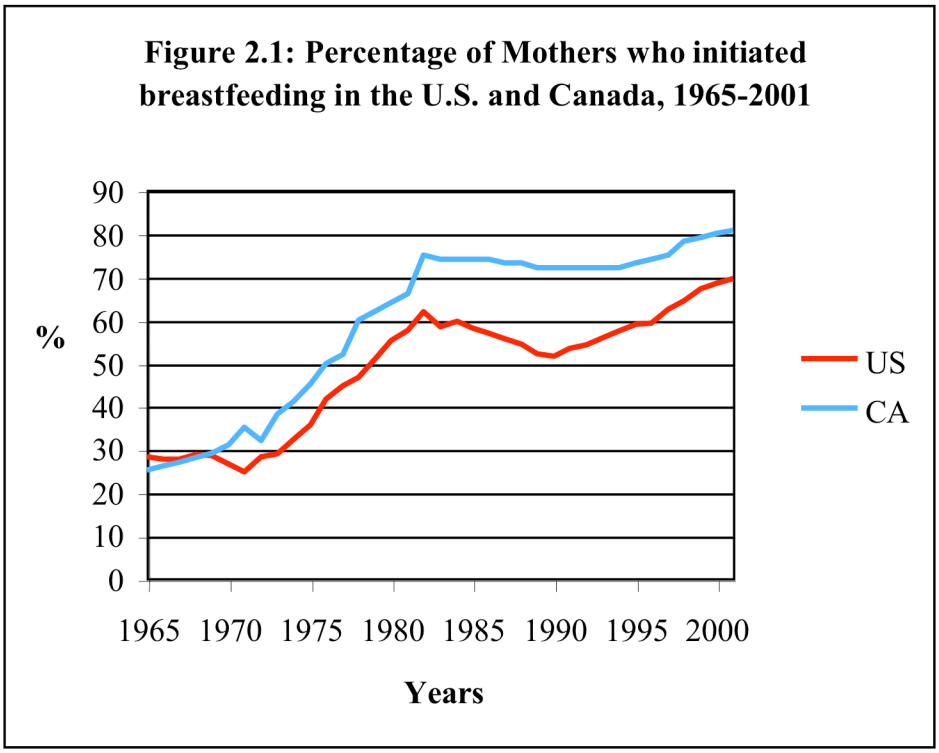
The efforts of these unlikely coalitions eventually resulted in a tangible success. In late 1978, the American Academy of Pediatrics (AAP), the major organization representing pediatricians in the United States and widely considered a significant influence on medical practitioners around the world, changed its official position to state

that "human milk is superior to infant formulas" (AAP 1978). This statement "marked the beginning of a trend, not only of the AAP but of the medical and public health profession as a whole, in supporting and promoting an increase in breastfeeding initiation and duration rates" (Prantik 2002:62). In 1979, the Canadian government and Canadian Pediatric Society (CPS) also became involved in a national campaign to increase awareness of the benefits of breastfeeding (Myers 1988). In fact, breastfeeding was encouraged in the *Canadian Mother's Book*, a nutrition guide distributed by Canada's Department of Health for Canadian mothers on raising infants and children. By 1990, the U.S. government also stepped up its level of participation in breastfeeding activism by making increasing breastfeeding rates part of the national health agenda, as seen in *Healthy People 1990* (U.S. Department of Health and Human Services 1980).

Therefore, by the end of the twentieth century, medical associations, maternalist and feminist lay activists, and U.S. and Canadian government organizations had successfully constructed infant feeding as a social problem and were all actively campaigning for an increase in breastfeeding rates. Figure 2.1 below illustrates breastfeeding initiation rates[2] over time in Canada and the U.S. We can see that although the rates in the U.S. and Canada were similar in the mid-1960s, since that point Canadian mothers have been much more likely to initiate breastfeeding their children than American mothers. Such a pattern suggests that there may be differences between locales regarding the cultural constructions of motherhood and the structural supports for breastfeeding mothers, including differing behaviors of medical practitioners, resulting in

[2] These rates are for initiation only, meaning a mother has to try to breastfeed only one time to be counted. Duration rates are those that account for the length of time that mothers have breastfed their children.

distinct behaviors.



Cultural Context for Breastfeeding Activism

Along with the growing interest in promoting breastfeeding by various activists, the late twentieth century also experienced a cultural turn towards a "new paradigm" of health (Moore 2008; Nettleton 2006). Such a shift was evidenced by an increasing focus on the importance of health to prevent disease and a growing amount of government participation in health promotion activities. Examples of the rhetoric of health promotion are visible in government initiatives (e.g., *Healthy People 2010* (U.S. Department of Health and Human Services 2000)), medical association journals, and statements by grassroots activists (e.g., *The Ottawa Charter for Health Promotion* (Canadian Public Health Association et al. 1986)) that focus on encouraging "health for all" as a means to

reducing social ills. Therefore, health was becoming a social concern but remaining an individual responsibility. Moore (2008) explains that:

> At the heart of this approach is the idea that health is a matter of individual responsibility, a commitment that entails, among other things, self-checking for symptoms of illness, readiness to seek medical help, and general awareness of one's susceptibility to ill health. (p. 272)

These shifts are an example of Foucault's (2008) concept of biopower, as powerful organizations (i.e., the government and medical associations) became increasingly involved in efforts to socially regulate people's behaviors through cultural beliefs about healthiness. Foucault's concept of biopower will be explored in more detail below.

Changes in the history of breastfeeding activism provide an excellent example of this cultural shift towards a new paradigm of health. The most engaged breastfeeding activism began with maternalists and feminists seeking to empower women as mothers. They wanted women to unite, provide mother-to-mother support and resist social control by the medical profession through the intrusion of formula. However, more contemporary breastfeeding arguments (i.e., after the 1980s) reveal a shift in the kinds of arguments used. In these arguments breastfeeding is less important as a spiritual and empowerment issue than as a medical issue that prevents risks and promotes the health of the child (and sometimes the mother). Such arguments have become increasingly popular over time with more and more participation by government and medical organizations in breastfeeding activism. In a sense, the language of breastfeeding activism was co-opted from women's rights organizations by the political and medical institutions in the late 1970s early 1980s. This change shifted the focus of breastfeeding activism from a unifying and empowering women's issue to an issue of social control and obsession with the health of the next generation. Although this move may have altered

the original goals of some breastfeeding activists (i.e., the feminists and maternalists), it also created an excellent discursive opportunity for lay, medical, and government activists to collaborate and unify their efforts.

What is a Social Movement?

The question remains, however, whether this coordinated effort constitutes an actual social movement. Scholars have worked hard to distinguish the activities of social movements from other collective behaviors. Recently, Snow, Soule, and Kriesi (2004) worked with the copious social movements research to develop a current definition of social movements. They define them as:

> collectivities acting with some degree of organization and continuity outside of institutional or organizational channels for the purpose of challenging or defending extant authority, whether it is institutionally or culturally based, in the group, organization, society, culture, or world order of which they are a part. (p. 11)

Therefore, social movements are networks of actors mobilized around a common issue using non-institutional forms of protest to challenge or defend existing authority structures. In the case of breastfeeding activism, an organization of collectivities—lay activists (e.g., LLL), medical scientists (e.g., CPS), and state actors (e.g., U.S. Department of Health and Human Services)—works toward the common goal of increasing the initiation and duration rates of mothers who breastfeed their infants.

Next, breastfeeding activism consists of, in part, non-institutional forms of protest, often motivated by lay activists, including a variety of "nurse-ins." For these events, breastfeeding mothers gather together at the site of a previous discrimination complaint by a nursing mother. Recent examples of this strategy include a national

nurse-in at airports across the U.S. responding to the ejection of a breastfeeding mother by Delta airlines for refusing to "cover up" (Associated Press 2006). A similar nurse-in was held at YMCAs in Canada in response to requesting that a nursing mother leave the pool deck while she was watching her older children's swimming lessons (Gorden 2007). However, given the participation by institutional actors (i.e., medical and governmental activists) within the movement as a whole, much of the activism in the breastfeeding movement is conducted within the bounds of bureaucratic authorities (e.g., policy recommendations and sanctioned public service campaigns). It is possible such a shortcoming is a consequence of the collaborative techniques of embodied health movements, which will be discussed below.

Finally, these groups have worked to defend existing voices of authority, which, in this case, is the voice of medicine. In fact, it was not until the collaboration of lay activists with government and medical activists that these groups began defending, while also contesting, the medical profession. Now that they use medically based arguments to promote breastfeeding, they are also working to defend the established authority of the medical profession. Particularly with the turn towards a new paradigm of health, medical organizations have preached a concern to reduce all possible risks for disease through regulating individual behaviors. In the case of infant feeding, these organizations argue that breastfeeding is likely to reduce the risks of multiple health threats including obesity, asthma, diabetes, and cancer and mothers should, therefore, be persuaded to breastfeed for the best health interests of their children. However, breastfeeding activists have not completely abandoned their medical criticism. Instead, they simultaneously challenge

and support medical arguments while working towards increasing breastfeeding rates, another unique attribute of embodied health movements (discussed in more detail below).

These characteristics suggest that breastfeeding activism qualifies as a social movement. However, some characteristics of the breastfeeding movement do not fit neatly within the bounds of previous social movements approach. In particular, the practice of simultaneously allying themselves with and contesting medical authority suggests that breastfeeding activism might best be understood in light of a health social movements perspective.

II. Health Social Movements

Moving beyond the traditional definition of social movements, breastfeeding activism is better described as an example of a health social movement (HSM). Brown and Zavestoski (2004) only recently began conceptualizing HSMs as distinct from traditional social movements. They define HSMs "as collective challenges to medical policy, public health policy and politics, belief systems, research and practice which include an array of formal and informal organizations, supporters, networks of cooperation and media" (Brown and Zavestoski 2004:679). Health social movements are activists' efforts to critically alter medical conceptualizations of illness, the kinds of medical research that is conducted, and the funding opportunities available for health research. An example of a successful HSM includes the women's health movement of the 1960s and 1970s, which compelled medical practitioners to redefine the female body and women's rights with regard to their body (Morgen 2002). Similarly, the mental patients' rights movement has changed people's ability to refuse mental treatment

(Brown 1984). As a collectivity, HSMs have played a critical role in challenging traditional medical authority structures and demanding a shift away from a medical model that promotes individual responsibility, and frequently self-blame, for health problems (Zavestoski et al. 2004).

Emergence of Health Social Movements

Health social movements have developed in response to a cultural shift in our understanding of expertise and a rise in scientific and medical authority. A "scientization" of government has occurred in which decision-makers have become increasingly dependent on science and technology as sources of "objective" knowledge and often use industry-supported science to back dominant political and socioeconomic systems (Morello-Frosch et al. 2005). By focusing on objective and expert analyses of health concerns, this cultural shift has helped disconnect debates regarding the costs, benefits, and potential risks of health policies from the social milieu in which the debates are taking place (Beck 1992). Health social movements have tried to break down this disconnect by democratizing the production of health knowledge. They have "leveraged medical science and public health to marshal resources, conduct research, and produce their own scientific knowledge" (Brown and Zavestoski 2004:681). Therefore, HSMs have emerged in an effort to reunite the discourses and practices of the medical field to the lived health experiences of a "sick" population.

Types of Health Social Movements

Brown and Zavestoski (2004) describe three ideal types of HSMs: health access movements, constituency-based health movements, and embodied health movements (EHMs). Health access movements are those searching for equitable access to health care, such as national health care reform. Constituency-based movements are those that address health inequality based on race, ethnicity, gender, class and/or sexuality differences. Lastly, EHMs are those that focus on the experience of a contested disease or illness. These activists use embodied experiences to challenge medical recognition of a disease and demand either more or different kinds of medical research and/or treatment. Although many health movements have overlapping foci, generally the dominant theme of an HSM can be put into one of these three categories. Until the 1970s, most health social movements focused on either access to care or discrimination based on social characteristics, however, more recent health movements, including the breastfeeding movement, have tended to be EHMs. These movements emerged from a personal understanding and experience of illness and have, interestingly, been likely to use alliances with health professionals, state agencies, scientists, and citizen-activists to challenge traditional medical authority and practice.

Embodied Health Movements

Embodied health movements "problematize the biological body, challenge existing scientific and medical knowledge, and involve collaborations between existing activists and scientists and health professionals" (Hess et al. 2008:479). Therefore, these activists use the body as a counter-authority to challenge medical science. However, in

their efforts to democratize the production of scientific knowledge, EHMs typically challenge existing medical/scientific knowledge and practice while at the same time collaborating with scientists and health professionals. I use breastfeeding activism to further investigate this strategy of challenging authority structures while simultaneously attempting to ally with them.

Embodied health movements are currently defined by three characteristics: 1) they often involve activists collaborating with scientists and health professionals; 2) they typically include challenges to existing medical/scientific knowledge and practice; and 3) they make the body central to social movements by using the embodied illness experience to legitimate their activities (Brown et al. 2004). The breastfeeding movement most certainly involves the collaboration of scientists and health professionals. In fact, the United States Breastfeeding Committee (USBC) is a government-sponsored group that began in 1995 as a group of independent breastfeeding advocates but became endorsed by the U.S. government and included governmental voting members in 2004. The group is now composed of medical organizations (e.g., AAP), lay organizations (e.g., LLL), and state organizations (e.g., U.S. Department of Health and Human Services). The similar Breastfeeding Committee of Canada (BCC) was established by Health Canada in 1991 and has a similarly diverse composition, including groups like the CPS, INFACT, and the Public Health Agency of Canada. Clearly, in both countries there are cross-institutional coalitions being formed in the name of breastfeeding activism, uniting health professionals with lay activists and the government to increase breastfeeding initiation and duration rates.

Challenges to existing medical/scientific authority often include critiques of topics of study, government funding sources, and corporate involvement in science (Zavestoski et al. 2004). Although some of the participants in the breastfeeding movement are sources of medical authority, there are simultaneous challenges to the authority of some scientific claims. In particular, activists have been critical of formula companies' sponsorship of infant feeding research, as well as the proliferation of formula promotion in hospitals. For example, many hospitals in the U.S. and Canada distribute formula samples and coupons when mothers are leaving the hospital post-partum. In fact, in July of 2007, activists succeeded in preventing New York City hospitals from distributing formula to new mothers and in banning formula promotional materials from the labor and delivery units in hospitals in order to "promote breastfeeding" (New York City Health and Hospitals Corporation 2007). These efforts demand that scientists and the public reconsider "who" should be allowed to "speak" about infant feeding.

Applying an EHMs perspective to the breastfeeding movement becomes a little tricky with regard to the experience of embodiment. As will be demonstrated below, many of the arguments used by breastfeeding activists focus on the physical health of the child; only sometimes do they focus on the mother. These arguments often use threats to the physical body, such as ear infections, asthma, obesity, and Sudden Infant Death Syndrome (SIDS), to persuade mothers to consider the future health of their son/daughter when they decide how to feed their infants. However, given the corporeal reality of breastfeeding, which can only be provided by the body of a mother, women embody the experience of breastfeeding. Furthermore, given the contemporary discourses surrounding motherhood (which will be discussed in more detail below), women are

often held responsible for the future health, development, and success of their children, such that failing to have a healthy child reflects as a failure of the mother. This kind of embodied activism by the breastfeeding movement seems to call for an expansion of the meaning of embodiment, with regard to EHMs, to include the experience of a mother's "pseudo embodiment" of her children's health.

Boundary Movements

An interesting characterization of EHMs is their ability to break through traditional movement boundaries. Embodied health movements cross boundaries both in their framing strategies, by forging strategic connections between health and other social sectors, as well in the alliances they hold, calling on activists from traditionally oppositional groups. Although such a practice seems similar to the social movements concept of "social movement spillover," where current movements can influence subsequent movements by altering the political and cultural landscape they confront (Meyer and Whittier 1994), this concept does not completely capture the nuances of EHM strategies. For example, EHMs simultaneously ally with and contest particular institutions and organizations. They challenge "the authority of science and medicine by working both inside and outside the boundaries" (Brown and Zavestoski 2004:687), using the power of medicine and science to contest contemporary medical interpretations. Furthermore, EHMs draw on arguments that resonate in particular socio-political climates, frames that may initially seem unrelated to the health issue at hand. These activists move fluidly between expert and lay identities, utilize accepted authority to challenge that authority structure, and bring together arguments and ideas from across a

variety of social issues, demonstrating in each of these strategies their ability to do boundary work.

According to McCormick, Brown and Zavestoski (2003), four characteristics define this kind of boundary work. First, activists in boundary movements engage in pushing science in new directions. Often, this activism demands a re-conceptualization of the difference between what is and what is not science or what is good versus bad science. Evidence of this strategy can be seen in the breastfeeding movement when some of the first medical professionals who took interest in this activism were part of a new and developing vein of science. Psychoanalysts, concerned with the mother-child bonding experience, helped push medical science to examine some of the non-corporeal consequences of formula feeding versus breastfeeding a child (Blum 1999; Eyer 1992). This activism to push science in new directions is also evident since the 1970s, when most of the research around infant feeding examined the benefits and advantages of the scientifically constructed formula as a legitimate alternative to breastfeeding. Both lay and medical activists have diligently worked to demand more research on the potentially negative consequences of formula feeding, by pursuing research that exposes the benefits of breastfeeding and challenges the scientific claim that formula is an equal alternative to breast milk. In each of these cases, movement participants have encouraged science to move in new directions and helped redefine what science means in relation to breastfeeding.

The second feature of boundary movements is their ability to blur the borders between experts and laypeople. By using resources, such as the Internet, to gain power over scientific knowledge, boundary organizations redefine medical authority. This

condition is evident in the breastfeeding movement as one examines the richness of resources for mothers seeking information about the experience of breastfeeding found on the Internet and in printed material. For example, on the American LLL website one can access the position statements of several medical professional organizations (e.g., AAP and the American Medical Association) asserting their support of breastfeeding. In this case, LLL uses the authority from these medical professional organizations in order to give credence to their own agenda—encouraging breastfeeding. Furthermore, as an organization that supports mothers through the experiences of other mothers, on this site one can read women's stories articulating their enjoyable experiences breastfeeding. The concept of supporting mothers through the lived experiences of other mothers is a prime example of lay expertise in the breastfeeding movement. Therefore, LLL is an excellent example of an activist organization that blurs the boundaries between scientific and lay knowledge as they draw on both in developing their authority on breastfeeding.

The next characteristic of boundary movements is their ability to simultaneously draw on and contest power structures. This tactic is particularly striking when actors across multiple locations hold a variety of relationships with the state or other experts while maintaining a unified movement philosophy. For example, the membership bases of both the USBC and the BCC are collaborations of diverse organizations including lay, medical and state agents combined into one representative association promoting breastfeeding. This union, however, is an unhappy marriage because while working with state and medical advocates to change individuals' behavior, lay activists are also working to change structural constraints to breastfeeding through government legislation. Therefore, governments have sponsored a collaboration of organizations that are actively

working to challenge state and medical authority as they demand structural support for breastfeeding. This ability to simultaneously ally with and contest particular institutions demonstrates the unique ways in which EHMs fluidly cross traditionally oppositional boundaries.

Finally, boundary movement activists draw on various ideas and frames from a variety of social movements and mold them for their own use. This strategy is demonstrated in Chapter Three, where I describe how activists from the breastfeeding movement link their arguments to the importance of protecting the environment, a concern for supporting the national economy, and the construction of breastfeeding in public as a human rights issue.

Given these definitions, it makes sense to understand breastfeeding activism as not just any kind of social movement, but as an EHM that does boundary work.

III. Breastfeeding Framing in the U.S. and Canada

With regard to social movements in general, the "new" cultural turn of social movement research has been well documented (Benford and Snow 2000; Goodwin and Jasper 2004; Johnston and Klandermans 1995; McAdam 1994), particularly with regard to research on collective action frames and framing processes. Similarly, rather than focusing on access to healthcare and health services, HSMs have begun to pursue the causes and cures for particular diseases or conditions, as well as the public recognition of such illnesses (Brown et al. 2002; Epstein 1996; Kolker 2004). Therefore, HSMs have also entered the business of constructing, or framing, particular health issues as a social problem.

In this section, I review the existing literature on framing in social movements and address the specific types of framing work used by activists in EHMs. I first define some key concepts, explaining what, exactly, a frame is and the kinds of framing activities that take place. Next, I describe the ways in which EHMs use framing for their embodied activism. Additionally, I address the particular tactics these activists use to construct risk around the undesirable behavior. Finally, I present the literatures on frame variation and their arguments for an increased knowledge of the ways in which activists differ in their framing within the same movement.

Framing Theory

Social movement scholars drew on and adapted Goffman's (1974) concept of frames, by emphasizing the importance of such an interpretive schema for mobilizing collective action (Snow et al. 1986). Snow and Benford (1986), the founders of the social movements perspective we know as framing, define this process as the active construction of reality done by activists in a social movement in order to mobilize potential constituents, garner bystander support, and to demobilize antagonists. This theoretical model advances previous models of examining and explaining social movements (e.g., resource mobilization and political opportunity[3]) in that it implies

[3] Resource mobilization theories stress the ability of a movement's members to acquire resources and use those resources to mobilize constituents. The main contribution of this perspective is to explain the dynamics of mobilization, to identify the type of resources and organizational features that condition the activities of social movements, and to focus on the relationship between the movements and the political system (McCarthy and Zald 1977). Political opportunity theory argues that the actions of activists are dependent on the existence (or lack thereof) a political opportunity in the broader sociopolitical context. Therefore, the political system will structure the opportunities for collective action (McAdam 1982; Tarrow 1989; Tilly 1978).

agency at the micro-level. The core tasks of the framing process are: 1) diagnosis, to focus blame or responsibility on someone or something for causing an identified problem; 2) prognosis, the offering of a proposed solution or at least a plan of attack to counter the problem; and 3) motivational framing, or a calling to arms or rationale for engaging in collective action. Certainly, being able to identify a problem, a target to blame, and a way to solve the problem are critical aspects in the process of mobilizing followers, and it is this agentic process of reality construction that was previously ignored by other approaches to social movements.

In order for frames to be effective in their persuasive goals, frames must resonate with their intended audience (McCammon 2001; McCammon and Campbell 2001; Noonan 1995; Reese 1996). Snow and Benford (1988) explain that cultural resonance is achieved when frames: 1) are salient to the public being addressed; 2) have empirical credibility or are verifiable with real world events; and 3) have "narrative fidelity" or resonate with cultural narratives and folklore. Empirical research suggests that adequate cultural resonance is not only important for increasing the mobilization capabilities of a movement (McCammon 2001), but also for achieving desired political outcomes (McCammon and Campbell 2001; Reese 1996). For example, Reese (1996) explores how California men and women organized to support state-sponsored childcare after the end of World War II. Key to gaining both cultural and political support was to frame the need for childcare centers in a maternalist way. By suggesting that supporting this childcare was supportive of "traditional" motherhood, activists were able to make it difficult for an opposition to develop and helped the movement succeed in policy reformation.

The development and dispersion of frames is a complex process. Such processes highlight how social movements are in the business of signifying work or meaning-making, whereby activists connect their frame with real events and experiences in order to amplify particular feelings related to the issue or event, making the issue more salient to the listeners (Benford and Snow 2000; Snow and Benford 1992; Taylor and Whittier 1995; Williams and Benford 2000). In fact, Benford and Snow (2000) describe the discursive process of frame development as the actual articulation and distribution of frames in the context of movement activities. Therefore, activists develop the "appropriate" language in order to resonate and motivate intended constituents and distribute them in propaganda and other forms of public speech acts. For this research, I examine frames present in informational resources (e.g., pamphlets and websites) from major stakeholders in breastfeeding activism, where activists not only explain the nuts and bolts of breastfeeding but also offer persuasive messages regarding why mothers *should* breastfeed rather than formula feed their children.

Embodied Health Movement Frames

Because EHMs contest traditional health authorities while also allying with them, they provide an excellent opportunity to examine traditional social movement tactics being used in a new and creative ways. We can see the use of typical framing strategies as health activists work to (re)construct the reality of a health issue in order to mobilize potential constituents, garner bystander support, and demobilize antagonists (Snow and Benford 1988). Furthermore, the use of culturally resonant frames is particularly important for EHMs given that their primary goal is to convince an audience of a

particular health threat and persuade them to think differently about the medicalization of that health issue—a challenging goal indeed. Again, EHMs are often working to redefine the label and experience of a particular disease or illness, which necessarily requires resonant framing and the strategic use of particular cultural resources increases that resonance. Such activists are working to persuade a population that a disease is a matter of national concern by diagnosing the problem in their framing strategies (Snow et al. 1986). In Mills' (1959) terms, they are working to redefine a personal trouble as a public issue. One health social movement strategy that has been examined is the use of cultural resources in their framing in order to better resonate with the general public (Kolker 2004).

Kolker (2004) examines the ways in which breast cancer movement activists used an epidemic frame, gender equity frame, and family erosion frame in order to demand increased federal funding for breast cancer research. This research builds on the "cultural turn" in social movements research, whereby scholars are less concerned with the questions of which frames have been most successful in recruiting participants or persuading beliefs, but rather ask questions about the expressive or cultural elements of movements and movement frames (Klawiter 1999; Polletta 1997; Wuthnow 1989). Such scholarship approaches framing "as a verb, something that social movement actors 'do' or embody…and emphasizes that social movements are involved in the business of signifying work, or producing meaning in the process of action" (Kolker 2004:822; see also Benford and Snow 2000; Klawiter 1999; Snow and Benford 1992; Taylor and Whittier 1995).

For this project, I examine how activists are able to construct a health threat with regard to infant feeding such that breastfeeding is recommended to prevent negative health outcomes while formula feeding, the alternative, is constructed as a "risky" behavior. Therefore, an effective construction of risk is one component of this analysis.

Risk Framing

In general, agencies concerned with public health must construct "risk" surrounding a particular behavior in order to achieve their goal of changing a community's lifestyle. They have to present this new information to the public as credible and as knowledge worthy of their consumption, assuming that after learning about the potential risks, the community members will alter their lifestyle (Lupton 1999). In this project, I examine how institutions strategically frame infant feeding as a risky behavior in order to establish breastfeeding as a contemporary public health concern and use morality as a source of coercion to encourage mothers to accept the recommended changes.

In addition to the core framing tasks that exist for all framing activities, Nathanson (1996) identifies three components necessary for an effective construction of *risk* with regard to public health policy change. We can see the presence of these conditions in breastfeeding framing. The first condition is "the existence of groups or individuals with the authority to define and describe the danger that threatens" (Nathanson 1996:615). This authority is usually attributed to the government and medical communities, both of which are active participants in the framing activism by the breastfeeding movement. The second condition to creating a credible risk is the

clarification, but not necessarily demonstration, of a causal relationship between a particular behavior and dangerous outcome. With regard to infant feeding discourses this would be the argument that formula feeding leads to an increased risk of negative health outcomes for the mother and child. Activists draw on evidence-based research to argue that particular feeding behaviors lead to different health outcomes for the child. The final condition is the "designation of potential victims" whereby the authority illustrates who, exactly, is going to be affected by this risk (Nathanson 1996:615). In the case of infant feeding frames, victims are designated when the content of the frame focuses on the negative health outcomes for the child and mother of formula feeding.

Frame Variation

From this perspective, the importance of framing lies in the way that frames, as meaning-constructing systems (Taylor and Whittier 1995), draw upon cultural ideologies to connect with and persuade audiences (Epstein 1997; Snow et al. 1986). However, the ways in which activists interpret the issues and construct their persuasive messages are not always the same. In fact, there are often differences in the framing strategies used by the various organizations that make up a whole movement. Scholars are beginning to take note of these intra-movement framing differences, acknowledging frame variation rather than assuming a homogeneity in framing strategies across organizations (McCammon 2009; Snow et al. 2007). Researchers have already noted that a movement's discursive strategy is subject to a variety of contextual factors, including political and cultural opportunities as well as the receptivity of the target audience. These factors impact the frames that movement actors choose to use, leading to some variety in

framing strategies (Diani 1996; Evans 1997; Johnston and Snow 1998; McCammon, Hewitt, and Smith 2004).

For example, McCammon, Hewitt and Smith's (2004) work on state-level suffrage movements illustrates how the target audience affects the framing strategies used in particular speech acts. Their research demonstrates that activists recognized how certain discursive strategies were more likely to resonate with certain groups and not resonate well with others. Therefore, certain discursive strategies were more likely to be used when addressing politicians while others were more appropriate for public use. Similarly, Snow, Vliegenthart and Corrigall-Brown's (2007) examination of frame variation in newspaper accounts of the French riots illustrates differences in how various actors speak about an issue at hand. For example, state, oppositional and international actors and residents and participants varied in their comments upon the events. Thus, both the intended audience and the structural position of the speaker reporting a particular frame constrains framing practices.

I build on this research by examining how different types of stakeholders in a movement are likely to draw on different framing strategies. In this case, I examine frame variation across organizational type and compare the framing strategies used by medical, government, and lay activist organizations. Each of these groups exerts a different kind of power in society and warrants different kinds of authority. As discussed earlier, one of the unique characteristics of HSMs is the collaboration of these traditionally oppositional groups. Although the ultimate goal for all of these groups is to increase breastfeeding initiation and duration rates, the secondary goals of these activists are competing and sometimes oppositional. For example, we have lay and medical

organizations encouraging the government increase legal support for breastfeeding mothers as well as lay and government organizations encouraging medical associations to develop more compelling research to demonstrate the importance of breastfeeding. Given the different secondary interests of each of these stakeholders, it is likely that their framing strategies will vary, while each is working for the same ultimate goal. This framing variation is explored below.

Another key to understanding frame variation is to understand the effects of competing discursive opportunities (Ferree 2003; Koopmans and Olzak 2004; Koopmans and Stratham 1999; McCammon et al. 2007). Koopmans and Stratham (1999) criticize scholars' focus on political opportunity structures and argue that researchers should examine the discursive field in which movement mobilization takes place. Discursive fields are the ever-evolving "terrain(s) in which meaning contests occur" (Steinberg 1999:748). They are part of the "broader enveloping contexts in which discussions, decisions, and actions take place" (Snow 2004:402). Therefore, shifts in the cultural environment (in addition to the political environment) create challenges and opportunities for social movement activists to shift their own approach and promote their cause drawing on the "new" framing strategy that is likely to resonate with a broad population. Koopmans and Stratham (1999) introduce the concept of "discursive opportunity structures" to capture the ways in which ideas in the larger political culture that are "considered 'sensible,' which constructions of reality are seen as 'realistic',' and which claims are held as 'legitimate' within a certain polity at a specific time" (228). Ferree's (2003) work on the abortion debate in Germany and the U.S., for example, illustrates different framing strategies used in different discursive opportunity structures. She

demonstrates that frames that are consistent with prevailing cultural discourses are more likely to be used and resonate in that environment. Therefore, in Germany, speakers emphasizing women's victimization and natural connection to the fetus become accepted as representing a realistic feminist position, thus mainstream, while those who would destigmatize abortion become marginalized. In the U.S., the reverse is the case.

In this project, I examine the role of discursive opportunity in framing strategies as I compare the frames used by breastfeeding activists in the United States to those used in Canada. The broad cultural shifts that lead to a "new paradigm of health" created a fertile "discursive field" for activists, on which they could draw inspiration for new framing and movement strategies. Despite this similar shift in both the U.S. and Canada, activists in both countries remain embedded in unique cultural circumstances that are likely to color the framing strategies used in each country. In fact, in Maioni's (1998) work on comparing health insurance policies in the United States and Canada, she argues that despite sharing many cultural and economic traits, these two countries differ dramatically in their approach to medicine and health care. Given the very different realities of healthcare in these countries, it likely that activists working towards a health-related reform will emphasize different framing strategies that are likely to better resonate with their constituents.

A challenge to examining frame variation is the comparative component necessary for the analysis. Over a decade ago, Benford (1997) provided an "insider's critique" of the current framing scholarship, arguing that "we lack systematic empirical studies across cases, movements, and time" (411). He argued that social movements researchers must examine the cross-cultural nature of particular movements as well as

study the negotiation that takes place in the development of collective action frames (Benford 1997). Contemporary researchers are continuing to call for more comparative research, especially with regard to frame variation (McCammon 2009; Snow et al. 2007). Specifically, Snow and his colleagues (2007) suggest more attention should be devoted to frame variation across different actors or different social locations all within the same event. My research responds to these calls by investigating framing strategies across organizational type within the same movement and by comparing the strategies of breastfeeding activists in both the United States and Canada. Addressing intra-movement framing differences at both the organizational level as well as cross-cultural level, I examine organizational and cultural factors that affect framing strategies.

Conclusion

In this section I outlined the theoretical basis for the first phase of analysis in this research. To summarize, I laid the foundation for an examination of the kinds of frames that are used in the breastfeeding movement and the ways in which breastfeeding activists are diagnosing infant feeding as a social issue and constructing formula feeding as a risky alternative. Furthermore, in my data analysis I build on the framing literature presented here by examining the multiple levels of frame variation present in breastfeeding activism. In particular, I examine framing differences at the organizational level, across different kinds of activist stakeholders including lay, medical, and governmental breastfeeding activists. Finally, I pay particular attention to how culture and structure affect the kinds of discourses activists use as their framing strategies.

These efforts to construct formula as dangerous to children's health illustrate ways in which the institutional actors attempt to exert control over people's health beliefs and behaviors. For this project, I am not only concerned with the macro-level construction of breastfeeding by activists. I am also interested in how the intended targets of these persuasive messages—mothers—are affected by these dominant discourses. In fact, for the second phase of analysis in this project, I examine women's own constructions of infant feeding and how these intersect with, challenge, or reaffirm the dominant discourses established by the state and other institutional actors. I address the theoretical foundation for this phase of analysis below.

IV. Risk in Breastfeeding Activism

One of the main goals of breastfeeding activism is the construction of formula feeding as a risky behavior. In this section, I outline the theoretical basis for the social construction of risk, a major goal of the breastfeeding movement. In an effort to connect these macro-level conversations about breastfeeding with the micro-experiences of motherhood, for this project I examine how mothers, the intended recipients of breastfeeding activism, understand breastfeeding. Therefore, I explore if and how mothers interpret and respond to these dominant discourses about infant feeding and the construction of formula feeding as risky.

Construction of Risk

In contemporary liberal societies, we tend to think about risk so much that many of our decisions about present behavior are marked by a consideration of future

consequences (Murphy 2000). For example, public health campaigns are designed to "warn the public about the dangers of certain activities, presuming that 'risky behavior' will be reduced as a result of the information transmitted" (Gabe 1995:3). However, we know that not every danger a community experiences is constructed as a public health concern. Rather, as social construction theorists have illustrated, there are social processes that determine if and how a given phenomenon is constructed as a social danger (Carpenter 2006; Nathanson 1996).

As an approach to studying the world, a social constructionist perspective argues that meaning is not inherent, but rather, meaning is socially constructed. The central concerns of constructionist inquiry are to study what people "know" and how they create, apply, contest, and act upon those ideas (Berger and Luckmann 1966). This approach builds on the theory of symbolic interaction. According to symbolic interactionism, society "exists" at the point of immediate social interaction because it is at this point where meaning (of objects, events, and behaviors) is captured. There are three premises to this theoretical framework. The first argues that "human beings act toward things on the basis of the meanings that the things have for them" (Blumer 1998:2). Therefore, it is critical for a researcher to uncover the meanings that people have attached to particular social objects and behaviors in order to make sense of the social world in which they live. The second premise of symbolic interactionism contends that the meanings of the object of study are "derived from, or arise out of, the social interaction that one has with one's fellows" (Blumer 1998:2). Rather than accepting an object's meaning as emanating from the intrinsic makeup of the object, the object's meaning actually evolves from a process of interaction. Therefore, through interaction, people construct the meaning of particular

objects or behaviors. The final premise of this theoretical perspective argues that "meanings are handled in, and modified through an interpretive process used by the person in dealing with the things he [sic] has encountered" (Blumer 1998:2). Accordingly, people do not behave based on what is objectively true, but rather they behave based on what they *believe* is true, and this belief is developed through a "process of interpretation" (Blumer 1998:2). Therefore, as a framework, symbolic interactionism argues that society is *socially constructed* through human interaction and interpretation. This constructed nature of reality is the basis of my theoretical approach as I speak with mothers about how they understand infant feeding.

However, given the corporeal reality of motherhood and fatherhood (i.e. to date, only biological females are capable of being pregnant and breastfeeding), I will also consider insights from Connell's (2002) social embodiment perspective. This approach argues that bodies are both objects and agents of social practice. In fact, he contends that "bodies cannot be understood as just the objects of social process, whether symbolically or disciplinary" because they are actual participants in this process through their capacities and developmental needs (Connell 2002:40). Therefore, I not only consider the ways in which these mothers construct infant feeding, but also how their lived, bodily experiences affect their interpretations of that reality.

Another component of this project is the nature of power exerted between constructors of risk and the intended consumers of that construction. Applying a social constructionist perspective to the study of risk allows me to examine the ways in which "all knowledge about risk is bound to the sociocultural contexts in which this knowledge is generated" (Lupton 1999:29). This perspective suggests that all knowledges in a

community, including risks, are simply one way of seeing the world. The way in which a community "sees the world," however, is a contested terrain, constantly being negotiated through social interaction. Accordingly, all knowledge is a social construct created in a particular historical moment and sociocultural setting (Lupton 1999). This knowledge is likely to shift across space and time, continually being reconstructed through social and cultural processes. By examining the cultural patterns associated with the ways in which certain phenomena are identified and dealt with as "risks," researchers can begin to uncover how concepts of risk are part of the worldviews of a community. This project is a step in this direction as I examine how mothers respond to the macro-level construction of formula feeding as a risky alternative to breastfeeding.

Biopolitics

This research examines the biopolitical efforts of breastfeeding activists, many of whom are members of the state or medical organizations, in order to shape and change women's health beliefs and behaviors. Foucault (1977) develops the concept of biopolitics in his discussion of a growing interest by the government to police the bodies of a population through the *legislation* of biopower (i.e., official health policies and laws structurally supporting/resisting particular health behaviors). Biopower refers to the mechanisms employed to manage the population and discipline the bodies of individuals. He argues that the health of a population matters to the state for economic reasons. Population reproduction and disease are central to economic processes and are therefore subject to political control. It is in the interest of the state to promote healthiness and healthy behaviors because a more efficient population provides for a more efficient state

(Foucault 1984:139). Given these political interests, the body has become a "political field," inscribed and constituted by power relations. At the heart of this power is the medical profession whereby "individual's lives are profoundly experienced and understood through the discourses and practices of medicine and its allied professions" (Lupton 1997:94). Gordon (1991) argues that biopower is the link between micro- and macro-levels of society. He argues it is "a politics concerned with subjects as members of a *population*, in which issues of individual sexual and reproductive conduct interconnect with issues of national policy and power" (Gordon 1991:4-5, emphasis in original).

One way in which this subtle and constant power is exercised is through the policies and state-supported recommendations regarding health beliefs and behaviors. This kind of "surveillance" medicine "moves the attention of medicine from pathological bodies to each and every member of the population…and gives way to the notion of risk" (Gastaldo 1997:116). Thus, much of our health is redefined as constantly being in an "at-risk state" (Armstrong 1995:400) and government behavioral recommendations can help us choose the "right" behaviors to maintain our maximum healthiness.

Conclusion

The second phase of analysis in this project draws on these concepts of social construction and biopower. As I discuss with mothers, in my interviews, how they conceptualize infant feeding, I uncover how they interact with the dominant discourse that defines breastfeeding as "good" and formula feeding as "bad." However, rather than assuming that these women can only construct their understanding of infant feeding

through their interaction with these discourses, I also consider how their embodied experiences affect their construction. It is their lived experiences that are likely to have the biggest effects on the mothers' interpretations of infant feeding because it is here that women's choices and behaviors are being constrained by their lived realities. Such a conflict between belief and reality gives women an opportunity to resist biopolitical efforts that are trying to make mothers feel badly about a particular behavior. In this case, mothers may be given an opportunity to withstand the pressures of biopolitically-endorsed guilt and reconstruct formula feeding as a perfectly suitable infant feeding option. I now examine previous scholarship that has researched breastfeeding discourses.

V. Previous Research: Contemporary Breastfeeding Discourses

In this section, I examine previous research on breastfeeding discourses. Research strongly establishes breastfeeding as the medical gold standard for infant feeding. Yet, as Figure 2.1 demonstrates, there are still a significant number of women in the United States and Canada who do not breastfeed their children. In an effort to increase breastfeeding initiation and duration rates, breastfeeding activists have tried to establish breastfeeding as, not only the best feeding option medically, but also as "the *moral* gold standard for mothering" (Knaak 2005:197; Blum 1999). It is the moral character of the breastfeeding discourse that is particularly problematic, transforming the context of choice (where a mother weighs the costs and benefits of breastfeeding and makes a decision best for her and her child) into a contested political terrain (where women feel that they *must* breastfeed so as to not seem like bad mothers).

Motherhood has been a field particularly dominated by "expert" advice. In fact, Apple (1995:161) has coined the term "scientific motherhood," to describe the belief that "women require expert scientific and medical advice to raise their children healthfully." Medical and social institutions tend to expect that a mother become knowledgeable about potential risks to her child and many suggest it is mainly her responsibility to ensure the health of her child, such that if she ignores expert advice then she is culpable for any health complication the child should incur (Arnup 1990; Lupton 1999). In connection with a neo-liberal modernism, people have become responsible for securing their own health and the health of those to whom they owe allegiance, making mothers accountable for their own as well as their children's health (Murphy 2001).

With regard to infant feeding method, mothers are encouraged to breastfeed by medical, activist, and state government organizations. These suggestions are made in light of research finding that formula feeding increases the likelihood of respiratory and gastro-intestinal infections (Howie et al. 1990), allergies, including eczema, asthma, food intolerance (Saarinen and Kajosaari 1995), insulin-dependent diabetes (Virtanen, Raanen, and Aro 1991), Chron's disease and cancer (Lawrence 1995), sudden infant death syndrome (Ford, Taylor, and Mitchell 1993), and impaired mother-infant bonding, confidence, and self-esteem (Lawrence 1995). However, Murphy (2001:295) argues that this:

> message that breast feeding reduces the short- and long-term risks of future disease or maladjustment cannot simply be treated as a neutral account of objective reality…[but rather] the injunction to breast-feed is one more way in which the 'good mother' is constructed and promulgated in and through the medico-scientific literature.

Several scholars have demonstrated the highly individualistic nature of contemporary pro-breastfeeding discourses insofar as they cast maternal behavior as the source of future disease and disadvantage, ignoring other determinants of health that are embedded in the social structure and placing responsibility on the mother for future outcomes (Blum 1999; Hayes 1992; Stearns 1999; Tapias 2006; Wall 2001). For example, in her analysis of breastfeeding discourses in Bolivia, Tapias (2006) found that the moral construction of breastfeeding over formula feeding seems to ignore the cultural reality in which these discourses are being received. Through her fieldwork and interview data, she found that the "larger structural constraints women may find themselves under are not taken into account in the education programs, and thus conflicts with local views claiming that a mother's milk can be unhealthy, unsafe, and in fact *the cause* of diarrhea and vomiting (and not a way to avoid it)" (Tapias 2006:102). Clearly, the construction of breastfeeding, even in non-Western societies, is such that mothers are viewed as almost solely responsible for the health outcomes of their children.

In her analysis of the historical and social constructions within which women's infant feeding experiences are framed, Blum (1999) suggests that infant feeding discourses have been part of broader discourses concerned with the control of mothering and that much of the dialogue has taken place in one of two models, a maternalist model and medical model of breastfeeding. The maternalist model, of which LLL is an example, celebrates motherhood and the embodied connection between mother and child that breastfeeding provides. On the other hand, the medical model focuses on the benefits of the milk itself, treating mothers as disembodied providers of milk who must be educated and scrutinized. Blum (1999) argues that there is both empowering and

oppressive potential within each model and that the escalating involvement of government in educational efforts provides researchers with an opportunity to more closely examine the extent to which such efforts are controlling and/or helpful. Given that her data analysis was completed almost ten years ago, I will explore the continued existence and changes in these models. Furthermore, by connecting broad social discourses with the micro-experience of infant feeding, this work sheds light on the relationship between the state and the public.

In her critical deconstruction of Canadian health education material, Wall (2001) highlighted connections between the moral nature of breastfeeding discourses and the cultural construction of nature and sexuality. She uncovered both of Blum's (1999) maternalist and medical models in her data such that "an emphasis on the unique, intimate, and embodied connection between mother and child is combined with efforts to convince women of the benefits of breast milk for their babies and technical advice that will help them to better manage their bodies in this regard" (Wall 2001:604). However, the role of women as independent agents becomes lost in this discourse. Mothers' needs and wants disappear and their behavior becomes legitimately subject to public scrutiny or moral authority and all structural barriers to a mother's ability to breastfeed become her own responsibility. Wall (2001) notes that rather than acknowledging or responding to the material and cultural realities that surround infant feeding decisions, activist literature reminds the mother that "breast is best" and provides tips including how to breastfeed discreetly in public or suggesting that the mother sleep when the baby sleeps. In this discourse women lose their agency and individuality and "become, in part, builders of better babies or burdens on the safety net" (Wall 2001:604).

These studies illustrate that there is often a moral construction of motherhood inherent in infant feeding discourses (Blum 1999; Knaak 2006; Murphy 2000; Wall 2001). In fact, in her analysis of mothering manuals from 1946 to 1998, Knaak (2005) discovered that the framing of a "good mother" as one who breastfeeds has consistently increased over time and that the context of choice for infant feeding method has decreased as the moral connection with breastfeeding and good motherhood has become stronger. Nonetheless, it is possible that these dominant discourses will strongly affect the way women interpret their experience of infant feeding, even if they are unable to follow the advice and breastfeed. For example, in Schmied and Lupton's (2001) interview study with first-time Australian mothers, they discovered that while nearly all of the women vehemently subscribed to the dominant discourse of "breast is best," their experiences were not always consistent with that discourse. In fact, some of the mothers found "the breastfeeding relationship between mother and infant was difficult to reconcile with notions of identity that value autonomy, independence and control" (Schmied and Lupton 2001:234). Therefore, these women felt conflicted because of their belief that breastfeeding was the best way to feed their baby, but it was ultimately a behavior with which they were uncomfortable. Through my interviews with mothers, I will be able to explore the mothers' responses to the dominant discourses regarding breastfeeding.

While at face value these discourses seem only to concern children's welfare and infant feeding practices, by examining the ways in which these messages construct the roles and responsibilities of women, we can see that they also illustrate the contemporary construction of femininity. In fact, the medical mandate to breastfeed has recently come

under criticism by a strand of feminist scholars who argue that the removal of choice on the experience of breastfeeding by the mandates of public health institutions is an exertion of power over women's bodies. Although feminists have participated in the breastfeeding movement, in the past they were resisting "control" over women's bodies by science and medicine. However, these new recommendations demand a particular behavior from mothers without regard to the structural pressures that may limit their ability to comply. Therefore, public health agencies have essentially co-opted a feminist argument (that breastfeeding is good) and turned it on its head. Several researchers have argued that public health campaigns that promote "breast is best" reflect the hegemonic power of health authorities to assert who should breastfeed and for how long (Blum 1999; Schmied and Lupton 2001). For instance, Blum (1999) has stated that the dominant cultural and medical model of breastfeeding today presents an unrealistic image of a "breastfeeding wage-earning Supermom" who gets to "carry her breast pump to work," maintaining her identity as a "good" mother who provides the best for her child. This icon, Blum argues, is problematic because few women, including women with socio-economic advantages, can live up to this vision. By constructing infant feeding as a "lifestyle" risk, rather than focusing on risk from external forces (e.g., pollution, natural disaster), breastfeeding activists tend to discount the sociocultural and structural constraints that may affect whether a women breastfeeds or formula feeds her child.

VI. Research Contributions

Despite these insights on the nature of breastfeeding discourse, research on this topic has been limited. Indeed, some researchers are puzzled by the lack of critical

debate from sociologists and feminists on the issue (Blum 1993; Schmied and Lupton 2001; Stearns 1999). While research has explored some of the decision-making processes regarding breastfeeding (Murphy 2004), much of it has been conducted in the public health field (c.f., Racine, Frick, and Guthrie 2009) that does not take into account the lived experiences and interpretations of the mothers being studied. Furthermore, significant time has passed since the publication of much of the work examining women's experiences with infant feeding (Blum 1999; Carter 1995; Tapias 2006). My research seeks to fill this void.

Thus far, I have outlined the theoretical basis for the following research inquiry. In this project, I build on social movement framing theory in several ways. First of all, I provide a cross-cultural examination of activist strategies within the same movement specifically contrasting the frames used by organizations in Canada to those in the United States. Therefore, this study addresses the significant need for more comparative research through a constant cross-cultural examination. I then layer this analysis with a comparison of the framing strategies across organizational types, each participating in breastfeeding activism. These findings contribute to our understanding of inter-organizational differences in framing strategies. Furthermore, these findings will enhance our understanding of the unique strategies and techniques used by EHMs.

In the second phase of analysis, I investigate how women's own constructions of breastfeeding intersect with, challenge, or reaffirm these dominant discourses. This micro-level analysis allows me to connect macro-conversations about infant feeding with women's lived experiences as mothers, responding to these activists' strategies while making sense of decisions that work best in their everyday lives. Drawing on symbolic

interaction literature and an understanding of social embodiment, this phase of investigation examines how women make sense of the dominant discourses for themselves while responding the challenges of their own lived experiences. Furthermore, these findings are also cross-cultural, as I compare the constructions of infant feeding by mothers in the U.S. and Canada.

This project is rare in its goal to connect the macro- and micro-levels of analysis by addressing both the organizational construction of breastfeeding as a social problem and mothers' own interpretations of infant feeding. In the next section I present the data and research methods used for these analyses.

Research Methods

This dissertation uses a combination of two qualitative research methods. I conducted a content analysis of documents from major stakeholders in the breastfeeding movement and in-depth interviews with the intended targets of these messages—mothers—in the U.S. and Canada. Pairing these two methods of analysis allows me to see the movement discourse from multiple angles. The textual analysis enables examination of the discourses produced by a relatively large number of groups in a systematic way, revealing variation within a representative sample. On the other hand, the interviews shed light on the "lived realities" of the women for whom these messages are intended (Geertz 1988). This section outlines these two methods of inquiry and discusses the study samples.

I. Data Sources and Collection

The data from this project are cross-cultural in nature. I first compare the social movement framing strategies of breastfeeding activists in the U.S. to those in Canada. Secondly, I compare data from interviews with mothers in Nashville and Toronto[4,5] . Comparing these research sites provides an excellent opportunity to examine the relationship between national beliefs about women's and mothers' roles in society and the local interpretations of breastfeeding messages. Although the United States and Canada share many cultural and economic traits, these two countries differ dramatically in their approach to medicine and health care. One structural difference between the two nations is the provision of universal health coverage in Canadian provinces whereas health insurance is an individual responsibility in the U.S. This is particularly relevant with regard to infant feeding because research suggests that breastfed babies can significantly reduce the cost of health care during a child's first year of life. As the cost of health care is a national rather than individual burden in Canada, there is likely institutional pressure to continually increase breastfeeding initiation and duration rates from a cost/benefit perspective. Although U.S. breastfeeding advocates have not been as successful at obtaining structural-level support from health professionals, they have recently made significant strides. As discussed above, in August 2007, New York City hospitals decided to no longer distribute bags of free formula to new mothers, replacing the formula with a breast-milk bottle cooler, disposable nursing pads, breastfeeding tips and a baby T-shirt with the slogan "I Eat at Mom's" printed on the front. This change suggests a cultural shift in the U.S. whereby health professionals may be more sensitive

[4] All names have been changed to protect the confidentiality of informants.
[5] Interview schedule available in Appendix A.

to the breastfeeding movement and moving towards a more similar perspective as that found in Canada.

These national-level differences, where Canadian breastfeeding activists have been much more successful in providing breastfeeding support to the public than those in the U.S., are also present at the local level in Nashville and Toronto. For example, with regard to city parental leave laws, in Toronto a woman is guaranteed up to 17 weeks pregnancy leave and up to 37 weeks maternity leave with pay at the discretion of the employer. Conversely, Nashville only guarantees 16 weeks of leave, for pregnancy or maternity, and pay is at the discretion of the employer. Therefore, we see some similarity in the offering of a leave with optional pay. However, Toronto provides a much greater leave time than Nashville. With regard to breastfeeding rates, Table 2.1 lists the actual rates for each of these cities in relation to the national goal rates. We can see that in general, Toronto has much higher breastfeeding initiation and duration rates than Nashville, so much so that the rates in Toronto actually exceed the national goal rates for the United States. These differing levels of success by breastfeeding advocates may be an effect of the different framing strategies utilized in each city. It is likely that the different successes breastfeeding advocates have made in each city are directly related to the culture in which the movement is embedded (Ferree 2003). In other words, the arguments being used in each locale will interact with the local culture and the interpretations of a similar argument may differ considering the cultural context.

TABLE 2.1 2003 CITY BREASTFEEDING RATES / NATIONAL GOAL RATES			
CITY	*EVER BREASTFED*	*BREASTFEEDING AT 6 MONTHS*	*BREASTFEEDING AT 12 MONTHS*
Nashville	72.8 / 75	36.9 / 50	18.1 / 25
Toronto	89.9 / 100	58.3 / 100	25.6 / 75

As selected research locations, Nashville and Toronto offer valuable comparisons as both are English-speaking, mid-to-large sized urban environments with a service-based economy. However, these spaces are also likely to provide variation in their framing strategies, in mothers' reception of these frames as demonstrated by the different breastfeeding rates, and in the available discursive and cultural opportunity structures. Studying women in Toronto and Nashville not only allows me to compare the Canadian and American cultural effects but also allows me to examine how different framing strategies may have led to varying levels of success for breastfeeding advocates.

Macro-level Data

For the first set of analyses, I examine the macro-level discourses within the breastfeeding movement by examining the framing strategies of organizations that participate in that movement. While frames can be distributed and consumed both verbally and textually, this project focuses on texts in which infant feeding is diagnosed as a social problem and breastfeeding is prescribed as the preferred infant feeding method. Therefore, the data for this portion of the project are texts that I am treating as discourses. Discourse "may be understood as a bounded body of knowledge and associated practices, a particular identifiable way of giving meaning to reality via words

or imagery" (Lupton 1999:15). By giving meaning to reality, discourses, particularly those developed by institutions, are used literally to construct a phenomenon and bring it into being because it is only through "discourses, strategies, practices and institutions that we come to know 'risk'" (Lupton 1999:85).

For this analysis I use policy statements and publications from major stakeholders in the breastfeeding movement, including major medical associations, governmental health entities, and grassroots activist groups in both the United States and Canada. Although each of these groups may be pursuing a similar goal—to increase breastfeeding initiation and duration rates—it is important to capture a sample from each of these organizational types in order to detect variation in framing methods that may exist across institutions. As is common in social science research, the true population of interest (in this case, all organizations actively working to increase breastfeeding initiation and duration rates in the United States and Canada) is unknowable, and therefore unattainable. However, I made exhaustive efforts to generate a study population that is wide reaching and inclusive.

The initial list of activist organizations grew from a "snowball" style of sampling of major groups participating in breastfeeding activism. First, I searched for the websites of the most notable participants in breastfeeding activism including the LLL, the BCC and the USBC. On their websites, each of these groups lists other organizations with whom they have coalitions in working towards their breastfeeding goals. Given the nature of EHMs (as discussed above), each of these organizations has coalitions with lay, medical, and governmental groups. Therefore, initially, each organization from these lists was added and examined for inclusion. Then, I examined the websites of the "new"

organizations, searching for a listing of additional coalitions. If any were found that were not already on the list, I included these new organizations as well. This research ultimately resulted in a list of 64 organizations for possible inclusion.

In order for a group to be included in the final study population, the organization had to meet a set of criteria that were derived largely from theoretical concerns. I first limited the sample to organizations with a publicly available website that provided breastfeeding information (e.g., policy statements, breastfeeding support information) to the casual reader. Given my interest in the ways broad cultural differences between the United States and Canada would affect the framing practices of breastfeeding activists, I focused on groups most likely to reach people from any portion of each country. The public availability of this information on a website makes the distribution of the material much broader across each country.

Secondly, I limited the sample to national-level social movement organizations. Again, I wanted a representation of organizations that make arguments that are most likely to affect any given portion of a country's population, rather than focused on a particular locale. Therefore, I visited the websites of all remaining organizations to further determine the appropriateness of inclusion in the study population. Upon doing so, I removed from the list any group that appeared not to be "actively" campaigning for increases in breastfeeding rates. I defined "actively campaigning" such that groups that had recently released policy statements or initiatives promoting breastfeeding and/or had recently updated information available to consumers intending to persuade them of the benefits of breastfeeding.

Thirdly, in order to best compare the strategies between activists in the U.S. and Canada, I limited the sample to parallel organization in each country. Therefore, after passing my initial criteria, I limited the included organizations to those with a matching presence in each country (e.g., the AAP in the U.S. and the CPS in Canada). The resulting study population included 20 organizations, listed in Table 2.2.

TABLE 2.2: LIST OF SAMPLED BREASTFEEDING ACTIVIST ORGANIZATIONS		
KIND OF ORG	*NAME OF ORG*	*WEBSITE*
CANADIAN LAY ORGANIZATIONS	Infant Feeding Action Coalition (INFACT)	www.infactcanada.ca
	La Leche League Canada (LLLC)	www.lllc.ca
	Newman Breastfeeding Clinic and Institute (NEWMAN[6])	www.drjacknewman.com
U.S. LAY ORGANIZATIONS	Ask Dr. Sears (SEARS)	www.askdrsears.com
	La Leche League (LLL)	www.llli.org
	Lamaze International (LI)	www.lamaze.org
CANADIAN MEDICAL ORGANIZATIONS	Canadian Paediatric Society (CPS)	www.cps.ca
	Canadian Pharmacists Association (CPA)	www.pharmacists.ca
	College of Family Physicians of Canada (CFPC)	www.cfpc.ca
	Society of Obstetricians and Gynaecologists of Canada (SOGC)	www.sogc.ca
U.S. MEDICAL ORGANIZATIONS	American Academy of Family Physicians (AAFP)	www.aafp.org
	American Academy of Pediatrics (AAP)	www.aap.org
	American College of Nurse Midwives (ACNM)	www.midwife.org
	American College of Obstetricians and Gynecologists (ACOG)	www.acog.org
CANADIAN GOVERNMENT ORGANIZATIONS	Health Canada (HC)	www.hc-sc.gc.ca
	Breastfeeding Committee of Canada (BCC)	www.breastfeedingcanada.ca
	Public Health Agency of Canada (PHAC)	www.phac.ca
U.S. GOVERNMENT	Department of Health and Human Services (US-DHS)	www.hhs.gov
	Special Supplemental Nutrition	www.fns.usda.gov/wic/

[6] No relation to the author.

ORGANIZATIONS	Program for Women, Infants, and Children (WIC)	
	United States Breastfeeding Committee (USBC)	www.usbreastfeeding.org

As this table shows, I included texts from three U.S. and Canadian lay activist organizations. The Canadian lay organizations include INFACT, La Leche League Canada (LLLC), and the Dr. Jack Newman (NEWMAN) website. Infant Feeding Action Coalition is a non-governmental organization based in Canada that is currently working to increase breastfeeding rates through participation in international policy setting meetings, such as the World Health Assembly. La Leche League Canada, is a Canadian offshoot of the U.S. LLL organization. Their goal is to provide mother-to-mother support for breastfeeding while educating mothers of the importance of breastfeeding for children, families, and society. Finally, the NEWMAN website is run by pediatrician Jack Newman. He developed the first breastfeeding clinic in North America designed to help struggling mothers establish a solid breastfeeding relationship with their child. On his website he provides considerable resources to mothers that claim to debunk myths about breastfeeding and offer guidance for women encountering breastfeeding problems. Additionally, he is the author of the bestselling book, *The Ultimate Breastfeeding Book of Answers: The Most Comprehensive Problem-Solution Guide to Breastfeeding from the Foremost Expert in North America* (Newman and Pitman 2000).

The three U.S. lay activist organizations include the Dr. William Sears website (SEARS), LLL, and Lamaze International (LI). Like Dr. Newman, Dr. Sears is a pediatrician turned breastfeeding activist. As one of the founders of attachment parenting, he strongly encourages breastfeeding as essential for developing a bond

between mother and child. His website offers a variety of texts intended to both help mothers who are breastfeeding as well as persuade mothers of the importance of breastfeeding. Also, he is the author of the best selling book, *The Baby Book: Everything you Need to Know about Your Baby from Birth to Age Two* (Sears et al. 2004). The LLL organization, as discussed above, provides a website for mothers to connect with other mothers and discuss maternal issues including breastfeeding. Finally, LI is an organization devoted to a natural approach to pregnancy and childbirth. Although breastfeeding is not their primary goal, they have several position papers and resource materials regarding the importance of breastfeeding.

For the medical organizations, I included four groups from Canada and four groups from the United States. The Canadian groups included CPS, the Canadian Pharmacists Association (CPA), the College of Family Physicians of Canada (CFPC), and the Society of Obstetricians and Gynaecologists of Canada (SOGC). Each of these medical organizations has recent (since 2004) statements and/or recommendations regarding the encouragement of breastfeeding as a social policy. Furthermore, these groups are currently working towards enacting activities that encourage mothers to breastfeed. Similarly, the U.S. medical organizations that I examined include the American Academy of Family Physicians (AAFP), the AAP, the American College of Nurse Midwives (ACNM) and the American College of Obstetricians and Gynecologists (ACOG). Again, each of these organizations has recently released a policy statement supporting the encouragement of breastfeeding for infants.

The government organizations that I examined include three groups from Canada and three from the U.S. The Canadian government organizations include Health Canada

(HC), which is the country's authority on national healthcare; the BCC, which, as I described above, is a government-supported collaboration of a variety of breastfeeding activists; and the Public Health Agency of Canada (PHAC). The U.S. government organizations included the U.S. Department of Health and Human Services (US-DHS), the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), and the USBC. All of these organizations had publicly accessible websites and were actively campaigning at the national level for increases in breastfeeding rates.

From these organizations, I collected texts for analysis including policy statements, tips and tricks of the trade for successful breastfeeding, and publications to encourage mothers to breastfeed (i.e., "Top Ten Reasons to Breastfeed Your Child"). Included documents were limited to those either published or updated between 2005 and February 2008 (when I completed data collection). Given the extraordinary amount of information available for mothers regarding breastfeeding, I limited the publications to the most recent or recently updated, as newly pregnant mothers were likely to find those pieces most relevant. These documents demonstrated the group's position on breastfeeding, and put forth their most compelling arguments for mothers to also believe that breastfeeding is the ultimate infant feeding method. I looked for documents that were intended as persuasive material which were listed as part of the group's "publications." Also, I tried to include some representation of each type of publication from every organization. Many of these were accessible as PDFs on the website but had also been distributed to local chapters of the national organization in order to further share with potential readers or as press releases. Across the 20 organizations that were included in the sample, 200 documents were gathered.

Micro-level Data

The second level of analysis was a micro-analysis, where I traced individuals' uses of and responses to these dominant discourses about breastfeeding. Such a multi-layered analysis allows me to explore the link between macro-conversations and micro-experiences. These interviews focus on women's own constructions of infant feeding and how they intersect with, challenge, or reaffirm the dominant discourses established by the state and other institutional actors. Therefore, I examined if and how the women had come across the discourses of the breastfeeding activists. If they had encountered the discourses, I explored how they interpreted this approach to infant feeding and whether these discourses affected their interpretations or experiences of infant feeding.

To garner this information, I interviewed 44 women: 22 from Nashville and 22 from Toronto. I developed the interview group from snowball sampling (Weiss 1994). In each city I posted fliers in several highly trafficked daycare locations, workout facilities, and laundromats. In addition, I requested participants on several online sources such as mothers' meet-up websites, forums for mothers to discuss and exchange ideas and make friendships via the internet, and a variety of email listservs. Following a snowball sampling technique (Weiss 1994), each of the women who responded to the call was asked, at the conclusion of the interview, to provide contact information for any other women whom they thought might be interested in participating in the project.

To be included in the study, the women either had to have a child less than one year old (including being pregnant with one's first child) or still be breastfeeding her child. The interviews took place in the home of the respondent, at a convenient location

of the respondent's choosing, or, if the respondent felt she was unable to meet with me in person, over the phone. All interviews lasted approximately one and a half to three hours in length. My interview guide was flexibly structured to give participants a chance to tell the stories they felt were important while also addressing a consistent collection of questions so that I can compare answers across respondents. The interviews, including those conducted over the phone, were audio recorded and transcribed in full. Table 2.3 lists the composition of the study sample, while Table 2.4 lists some descriptive statistics for the sample.

TABLE 2.3: RESPONDENT CHART (N=44)						
NAME	*CNTRY*	*AGE*	*RACE/ETH.*	*# OF CHILDREN*	*EDUC. LEVEL*	*CLASS*
Abbie	CA	32	Asian	1	BA	Middle
Alexa	US	29	White	2	MA	Middle
Anna	CA	31	Asian	1	BA	Middle
Ashley	US	25	White	1	BA	Middle
Audrey	CA	41	White	3	BA	Middle
Autumn	US	23	White	1	HS	Working
Avery	CA	31	Asian	1	MA	Upper
Caroline	CA	31	White	1	CPA	Upper
Claire	US	36	White	1	BS	Middle
Diana	CA	36	White	1	BA	Middle
Elizabeth	CA	32	White	1	MA	Middle
Ella	CA	38	White	2	BA	Middle
Emily	US	28	White	1	MA	Middle
Faith	US	30	White	1	BA	Middle
Grace	US	29	White	1	BA	Middle
Hailey	CA	39	White	2	HS	Working
Hannah	US	30	White	1	BA	Middle
Isabel	US	32	Hispanic	1	JD	Upper
Jada	CA	41	White	3	HS	Working
Jasmine	CA	28	Asian	1	BA	Upper
Jennifer	CA	28	White	2	BA	Middle
Jessica	CA	31	White	2	HS	Middle
Jordan	CA	39	Native	2	HS	Middle
Julia	CA	24	White	2	HS	Working
Katie	CA	23	White	1	HS	Working
Leah	US	24	Hispanic	4	HS	Working
Lily	US	36	Hispanic	2	JD	Upper
Linda	US	37	Black	1	MD	Upper
Margo	US	35	White	2	MS	Middle
Madison	US	36	White	2	MA	Middle
Mariah	CA	39	White	4	BA	Middle
Maya	CA	30	Hispanic	2	HS	Middle
Michelle	US	42	White	2	HS	Middle
Molly	US	36	White	2	MA	Middle
Morgan	US	29	White	1	BA	Upper
Natalie	US	37	White	1	HS	Middle
Olivia	US	29	Hispanic	1	MA	Middle

Rachel	CA	37	White	2	HS	Middle
Samantha	CA	28	White	1	BA	Middle
Sarah	US	31	White	1	MA	Middle
Stephanie	US	27	Black	1	BA	Middle
Sydney	US	26	White	1	BA	Middle
Taylor	CA	37	White	1	HS	Upper

TABLE 2.4: DESCRIPTIVE STATISTICS OF INTERVIEW SAMPLE (N=44)		
COUNTRY	US	50% (22)
	CA	50% (22)
AGE	Range	23-42
	Mean	32
RACE	White	73% (32)
	Hispanic	11% (5)
	Asian	9% (4)
	Black	5% (2)
	Native	2% (1)
# OF CHILDREN	1	57% (25)
	2	32% (14)
	3	7% (3)
	4	5% (2)
EDUCATION	High School	30% (13)
	BA/BS	36% (16)
	Post-Grad	31% (15)
CLASS	Working	11% (5)
	Middle	70% (31)
	Upper	18% (8)

The women's ages ranged from 23 to 42 years old, with the average age for a participant being 32. They had between one and four children each. A majority of the participants (57%) had only one child while the average number of children per household was 1.6. This sample's educational distribution was skewed towards an educated population such that a majority of the women (67%) had at least a college

degree while 34% had completed some form of post-graduate education. Finally, I coded each of the women into a class category using their education and income such that I categorized 11% of the sample as working class, 70% of the sample as middle class, and 18% of the sample c as upper class.

Data Analysis

I used two techniques to analyze the data in this project: 1) content analysis of frames and 2) a detailed, in-depth grounded theory analysis of interview data. This dissertation includes two data analysis chapters, each addressing one level of analysis using one of these techniques. In the first analysis chapter, I discuss the results of a detailed content analysis of the literature from breastfeeding movement organizations. Including groups that represent three different kinds of institutions (medical, government, and lay activist groups) as well as including groups from both the United States and Canada allows me to illuminate the various framing strategies used by breastfeeding activist organizations. Furthermore, such a sample captures the discourses distributed across a variety of social fields in order to better understand the ways in which these organizations are constructing infant feeding at a national level. In the second analysis chapter, I draw on qualitative interviews with mothers, from Nashville and Toronto, to compare cross-culturally how women's understanding of infant feeding intersects with, challenges, or reaffirms the organizational construction of breastfeeding.

Content Analysis

Each of the institutions I studied has attempted to change mothers' behavior with regard to infant feeding through the development and/or promotion of public policies and constructing infant feeding as a "risky" behavior. Therefore, I use content analysis to critically deconstruct this breastfeeding material, "calling into question that which goes unchallenged in the presentation of issues and in debates over these issues: the 'facts,' 'descriptions,' and perceived common knowledge" (Wall 2001:595). This approach allows me to explore the situated embeddedness of the infant feeding discourse. Activists often try to "invest discourses with their preferred meanings," usually because they want to impose their ideology onto the meaning of words (Steinberg 1999:745). This competition and negotiation of power over the meaning of discourse is in a constant state of flux. Therefore, the frames that activists use to persuade mothers are likely to be culturally dependent on both the geographical location of the organization (i.e., in the U.S. or Canada) as well as the kind of organization that is speaking (i.e., lay, medical, or government activist organization). Thus, a content analysis of breastfeeding promotional material will reveal the variety of meanings of infant feeding and constructions of formula as a risky feeding option. This research will not only illustrate the socially constructed nature of everyday language, but the multivocality and contestedness inherent in discourse (Klawiter 2008).

Chapter Three offers a detailed content analysis of organizational literature distributed by activists in the breastfeeding movement. The first step was to identify key movement frames (i.e., those used repeatedly by a portion of the sample). I used Atlas.ti, a qualitative data analysis software, to code all organizational texts for the presence of

collective action frames. I first approached the texts using a procedure commonly referred to as "open coding" (Strauss 1987; Strauss and Corbin 1990). At a basic level, coding is the process by which the researcher begins to extract meaning by identifying and providing labels for pieces, or "chunks," of the data (Hesse-Biber and Leavy 2005). Open coding is often the first step in analyzing qualitative data, and consists of "breaking down, examining, comparing, conceptualizing, and categorizing data" (Strauss and Corbin, 1990:61). For example, see the following quote from the USBC's statement on Exclusive Breastfeeding (USBC 2000):

> The United States Breastfeeding Committee's considered opinion is that healthy full-term infants be exclusively breastfed for about six months. This point of view is supported by expert opinions such as those expressed in the American Academy of Pediatrics' Policy and the American College of Obstetricians and Gynecologists' Educational Bulletin regarding the positive impact of breastfeeding on women's health, infants' health, and then enhanced relationship between mother and infant.

This paragraph was initially coded as an example of: baby-saving framing, mother's health framing, bonding, cite medical organizations, cite AAP, cite ACOG, exclusive breastfeeding, recommend six months. This first pass through the data was followed by numerous coding sessions through which the coding scheme was refined repeatedly, adding, deleting, renaming, and merging codes along the way. Although I anticipated the presence of frames such as baby-saving and formula risks based on my pre-existing knowledge of the movement, I did not begin the coding process with a formal list of codes; rather, I allowed codes to emerge from the data (Charmaz 2006).

Although I coded multiple uses of the same frame (when they existed) within the same document, ultimately I am not concerned with how many times each organization used a particular frame, but rather with how many and what kinds of organizations use

each type of frame as well as across how many publications a single organization will use the same frame. The primary outcome of interest is simply the presence or absence of frames in the organizational document. After the codebook was established, each document was (re)coded for the presence or absence of five frames (i.e., baby-saving, mother's health, formula risk, rights frame, and social good). Again, even though it was possible for a document to offer an individual frame more than once, in such cases, the category was counted only once. The distribution of these frames will be discussed in detail in Chapter Three.

In-depth Interviews

Chapter Four connects the macro-level discourses about breastfeeding with mothers' lived experiences and their own interpretations of infant feeding. I interviewed a total of 44 women. As I interviewed more and more women, I began to recognize repeated patterns in the words and ideas of respondents, what Glaser and Strauss (1967) refer to as "saturation." When new respondents began to repeat information and ideas already identified through previous interviews, this saturation point had been reached and I stopped pursuing additional participants.

I approached this data analysis from a modified grounded theory perspective. This approach to the development of theory begins with a set of cases and builds the theoretical analysis from the finding in the worlds that are being studied (Charmaz 1983; Glaser and Strauss 1967). Charmaz (2001:336) describes the distinguishing characteristics of grounded theory methods, which include:

> (1) the simultaneous involvement in data collection and analysis phases of research; (2) creation of analytic codes and categories developed from

> data, not from preconceived hypotheses; (3) the development of middle-range theories to explain behavior and processes; (4) memo-making, that is, writing analytic notes to explicate and fill out categories, the crucial intermediate step between coding data and writing first drafts of papers; (5) theoretical sampling, that is, sampling for theory construction, not for representativeness of a given population, to check and redefine the analyst's emerging conceptual categories.

Therefore, my coding of the interviews was an iterative process that allowed me to change the interview guide to better address particular issues that emerged as important in my coding.

Again, I used Atlas.ti to code the transcripts of these interviews. I coded the interviews for themes and processes and wrote analytic memos on developing patterns as a way of making sense of what was happening. Furthermore, analysis of the textual data resulted in a two-step process in which the initial round of analysis developed and refined theoretical categories used to code the data while the second round applied the newly refined codes to the broad body of the text (Johnston 2002). I examined these interviews for the ways in which these women understood breastfeeding, how they responded to dominant discourses about breastfeeding, whether and/or how they interacted with the discourses of the breastfeeding movement, whether and/or how their conception of "good" motherhood was bound up in their understanding of breastfeeding, and whether or not they considered formula feeding to be a risky alternative to breastfeeding. A thorough discussion of these findings is presented in Chapter Four.

Conclusion

This section has discussed the two complementary methods of inquiry used in this dissertation. In this study, I conducted a content analysis of 200 documents from 20

breastfeeding activist organizations in Canada and the United States. Secondly, I conducted in-depth interviews with 44 mothers from Toronto and Nashville. Both of these sets of data, the organizational literature and interview transcripts, were coded using Atlas.ti as the tool and grounded theory as the approach. The following chapters present the most significant themes identified through these methods of inquiry and analysis.

CHAPTER III

FRAMING STRATEGIES IN THE BREASTFEEDING MOVEMENT

Introduction

Previous research on breastfeeding activism has not considered these campaigns in light of social movements literature. I begin this chapter by outlining the frames and arguments used by breastfeeding activists in the United States and Canada. Then, drawing on the emerging literature examining health social movements, I address how the frames used by breastfeeding activists exhibit "embodied" characteristics and utilize boundary-crossing strategies (Brown et al. 2004; Zavestoski et al. 2004). Therefore, as discussed in Chapter Two, I demonstrate how breastfeeding activism captures the embodied experience of illness and crosses boundaries by simultaneously challenging and collaborating with scientists. Next, I investigate variation in these framing strategies. I start this analysis "at the top" and examine how and why the framing strategies used in the United States are similar to or different from those used in Canada. This analysis allows us to examine the ways in which a specific context expands and constrains the cultural resources from which frames, or movement arguments, are drawn. Then, I address differences in strategic framing across organizational types by looking at how the framing strategies of lay, medical, and governmental activist groups compare. Furthermore, I explore how strategic coalitions affect the tactics used in the movement as a whole (cf. Klawiter 2008). Finally, I examine the differences between organizational types and by country. These findings contribute to our understanding of inter-

organizational heterogeneity in social movement framing strategies, as well as of the unique coalitions that are made in health social movements.

In this chapter, I examine breastfeeding framing using data collected through a content analysis of organizational texts. To do this I analyzed a sample of 200 documents intended to persuade mothers to breastfeed their infants (details of data collection are addressed in Chapter Two). These documents are distributed across organizational types (i.e., government, medical, and lay activist) and across geographical locations (i.e., the U.S. and Canada). As discussed in Chapter Two, each document was coded for the presence or absence of five frames (i.e., baby-saving, mother's health, framing risk, rights frame, and social good). Table 3.1 (below) provides an overview of these frames among my sample, as well as the percentage of documents engaging in the use of each type of argument. Note that the total percentage for all categories combined is not 100 as it was possible for a document to offer more than one frame. It was also possible for a document to offer an individual frame (e.g., mother's health frames) more than once. In such cases, the category was counted only once. I now discuss each category of frames and provide examples from the documents.

Breastfeeding Framing Strategies

As discussed in Chapter Two, health social movements are distinctive in their ability to draw on the embodied experiences of illness and, therefore, cross traditional movement boundaries from the external world to the visceral experience. In this section, I examine what frames are being used in the breastfeeding movement and how they exhibit embodiment and boundary work. In their effort to influence mothers' health

beliefs and behaviors, activists have constructed lack of breastfeeding as a social problem; an issue that deserves attention and concern from mothers, medical practitioners, government officials, and the community at large. They have, therefore, drawn on viable cultural resources in their effort to create resonant frames.

I. Frames used by the Breastfeeding Movement

I uncovered a variety of framing strategies in my analysis of persuasive material developed by activists in the breastfeeding movement. These arguments were intended to persuade women to breastfeed rather than formula feed their infants. Most of these framing strategies were diagnostic, that is, they identified a problem and assigned cause and effect to that problem (Benford and Snow 2000). The diagnosis, in this case, was that breastfeeding should be the preferred infant feeding method and that not all women were breastfeeding their infants. Therefore, the cause of the problem remained the same across movement arguments, that mothers were not breastfeeding their infants. The purported consequences of this failure, however, varied across framing strategies such that some focused on the importance of preventing potential health risks to the mother and child while others addressed a communal responsibility with regard to infant feeding. Furthermore, some of the frames had a motivational component as well, encouraging women to feel empowered by both the breastfeeding movement and the act of breastfeeding.

TABLE 3.1: FRAMES USED BY BREASTFEEDING ADVOCATES	
Framing Strategy	*Percent of Documents Using Frame (N=200)*
Preventative Health	
Baby-saving Frame	59% (118)
Formula Risk Frame	30% (59)
Mother's Health Frame	25% (49)
Social Responsibility	
Social Good Frame	15% (29)
Rights Frame	13% (25)

Preventative Health Frames

Through the active construction of formula feeding as a dangerous behavior, breastfeeding activists intend to change mothers' health beliefs and behaviors such that they feel compelled to breastfeed rather than formula feed their children. The most common approach to making this case was a focus on preventive health. Therefore, activists "diagnosed" the potential illnesses or other negative health outcomes (effects) that could result from failing to breastfeed (cause). However, in addition to noting the potential negative health outcomes that could be experienced by failing to breastfeed, these arguments motivated mothers to breastfeed by drawing on several resonant cultural resources. First of all, they employ the contemporary ideology of motherhood, which demands that mothers provide the supreme amount of support and care to their children and therefore take all necessary preventative measures to ensure that their child is healthy

and well adjusted (Hays 1996; Wall 2004). Secondly, as part of a general progression toward "high-level wellness," in which individuals maximize their capacity for health and fitness, parents are expected to prepare their children for optimal health (Goldstein 1992). Activists draw on this cultural expectation in their rhetorical strategies that encourage mothers to breastfeed to prevent potential negative health outcomes for their children. Finally, these framing strategies take advantage of increasing biopolitical[7] efforts by government and medical associations to alter people's health beliefs and behaviors for the good of society (e.g., more productive and efficient workers, lower health care costs) (Foucault 1977; Rose 2006).

Activists used variations on three major framing categories in their construction of breastfeeding as a preventive health behavior: baby-saving frames, formula risk frames, and mother's health frames (see Table 3.1 for percentages of overall number of frames). The other two frames used by breastfeeding activists, the social good frames and rights frames, focus on the community support necessary for women to breastfeed their children successfully and will be discussed below. I now explore the differences in these framing strategies.

Baby-saving Frames

Fifty-nine percent of the documents sampled used a "baby-saving" approach in their endorsement of breastfeeding, which is more than twice as much as any other

[7] Biopolitics is the legislation of biopower, or a formal political intervention into a government's efforts to control a population's physical body. Such regulatory power is exerted to create productive, powerful, and *docile* bodies. States intervene in order to enhance the birth, death, and health rates for the given population. We see biopolitics as the object of study in demography and government interventions to "correct" unwanted demographic patterns. For a more complete discussion of biopolitics, see Chapter Two.

approach. In this argument, activists make the case that breastfeeding is a key ingredient in raising a healthy child and preventing a variety of illnesses, even death. Activists created three versions of the baby-saving frame, including a scare tactics approach, a focus on the child's emotional health, and an emphasis on the mental development of the child.

Scare Tactics

In the most popular formulation of the baby-saving frame activists employ a scare tactic of sorts, listing the potential health risks babies might experience if they are not breastfed. For example, we can see this kind of baby-saving frame in a pamphlet available on Canada's Public Health website. Here they argue that breastfeeding:

> helps prevent constipation; helps to protect against childhood diabetes and childhood obesity; helps to protect against ear, chest, and stomach infections; helps to protect against allergies and asthma; helps to protect against Sudden Infant Death Syndrome (SIDS); helps to prevent tooth decay; [and] may lead to smarter children (Toronto Public Health 2009).

We can see a similar approach by a U.S. government run website, womenshealth.gov, which argues that:

> infants who are not breastfed have higher rates of sudden infant death syndrome (SIDS) in the first year of life, and higher rates of type I and type II diabetes, lymphoma, leukemia, Hodgkin's disease, overweight and obesity, high cholesterol and asthma (National Women's Health Information Center 2005).

These statements attempt to increase the urgency with which mothers should accept breastfeeding as the preferred infant feeding method by linking the failure to breastfeed with serious health risks, including the possibility of death (i.e., SIDS). In this version of

the baby-saving frame, the arguments focus on enhancing the physical health of the child and reducing the risks of future disease.

Even though these arguments are portrayed as absolute, scientific fact, these arguments are better understood as a rhetorical strategy to persuade mothers of the health threats to their children (c.f., Best's (1990) work on the construction of the child-victim). In contrast to this absolutist presentation, the evidence is more accurately described as suggestive and inconclusive. Although a considerable amount of medical research has been conducted to demonstrate the health benefits of breastfeeding over formula feeding, some researchers argue that the findings from these studies overstate the impact of breastfeeding on children's outcomes. In breastfeeding studies, "potential confounding makes it difficult to isolate the protective powers of breast milk itself or to rule out the possibility that something associated with breast-feeding is responsible for the benefits of breast milk" (Wolf 2007:602). Therefore, despite the number of studies that have linked breastfeeding with favorable and formula feeding with unfavorable health outcomes, other researchers have argued that these results emerged from study design flaws. Studies using different methodologies (e.g., comparing siblings' health outcomes when fed differently) have revealed that many of the previously touted correlations between breastfeeding and positive health outcomes become statistically insignificant (Evenhouse and Reilly 2005). For example, some researchers argue that breastfeeding does not reduce obesity (Kramer et al. 2008) or significantly decrease the likelihood of ear infections (Paradise et al. 1997).

Emotional Health Frames

Another adaptation of baby-saving frames is a discussion of the child's emotional health, which often emerges as a discussion of the bonding between mother and child. Canadian medical activist, Jack Newman, for example, articulates the importance of a child's psychological health in a handout. Dr. Newman is an internationally known breastfeeding activist and the founder of the first breastfeeding clinic, located in Toronto. Dr. Newman's handouts are publicly available online (on his website as well as various breastfeeding and mothering support websites, including American-run websites) and he is the author of a best-selling (in both the U.S. and Canada) breastfeeding book, *The Ultimate Breastfeeding Book of Answers: The Most Comprehensive Problem-Solution Guide to Breastfeeding from the Foremost Expert in North America* (Newman and Pitman 2000). In one particular piece, Dr. Newman suggests that the act of breastfeeding means much more than simply sustenance. He argues that, "the most important aspect of nursing a toddler is the special relationship between child and mother. Breastfeeding is a life-affirming act of love…there is something almost magical, something special, something far beyond food going on" (Newman 2003).

The United States Breastfeeding Committee (USBC) confirms this argument when they state that breastfeeding provides "an enhanced relationship between mother and infant" (USBC 2000). This framing strategy, which constructs breastfeeding as an "act of love," puts another layer of pressure on mothers to breastfeed insofar as mothers might interpret the reverse of this argument to mean that those who fail to breastfeed their child somehow love their children less than mothers who breastfeed. Statements such as these, however, have very little evidentiary support. For example, Else-Quest, Hyde, and

Clark (2003) note that despite regular claims that breastfeeding increases the bonding relationship between mother and child, very little research has been done to substantiate those claims. In their own research, they find that although breastfeeding mothers "tended to show higher quality relationships [with their infants] at 12 months, bottlefeeding dyads did not display poor quality or precarious relationships" (p.495). Similarly, a more recent study "found no evidence of risks or benefits of prolonged and exclusive breastfeeding for child and maternal behavior" (Kramer et al. 2008: e435). Therefore, even these more ambiguous claims, suggesting that breastfeeding may lead to a closer and more intimate relationship between mother and child, have been unsubstantiated by scientific research.

Mental Development Frames

The third variant of the baby-saving frame focuses on the mental development and IQ of the child. For example, in the following excerpt from the American Academy of Family Physicians' (AAFP) breastfeeding statement, we see an emphasis on how breastfeeding contributes to a child's intelligence. They write, "Studies of intelligence and development have also shown lower IQ and lower developmental scores among children who were not breastfed" (AAFP 2008). Following these same lines, a USBC information sheet on the benefits of breastfeeding contends that one of the "Costs of Not Breastfeeding" is a "3- to 11- point IQ deficit in formula-fed babies; [and] Less educational achievement noted with formula-fed children" (USBC 2002c). This push for parents to be concerned with the intelligence and learning capacity of their child resonates in a contemporary climate where education is key to accessing successful

careers. However, this argument is certainly contestable. Although some research makes the claim that breastfeeding increases IQ (c.f., Lykke, Fleischer, Sanders, and Reinisch 2002), other research suggests that the relationship between breastfeeding and intelligence is much more complicated than originally presented. For example, Der, Batty and Deary (2006) argue that the intelligence level of mothers moderates the relationship between breastfeeding and a child's intelligence.

Despite the controversial nature of some of their claims, these baby-saving arguments were the most common framing strategy in this sample of documents, each arguing that "breastfeeding supports [children's] optimal development and protects against acute and chronic illnesses" (USBC 2002a).

Formula Risk Frames

Scholars have demonstrated that a key step in creating an effective public health campaign is the construction of risk (Nathanson 1996). Activists must successfully persuade a community to willingly alter their health beliefs and behaviors because of the potential negative health outcomes associated with the given behavior. Drawing on the authority of medicine, activists have tried to construct formula as the risky alternative to breast milk. This strategy was present in 30 percent of the documents sampled in this study.

In the previous framing strategy, the riskiness of formula consumption is implied. Rather than explicitly blaming or connecting formula feeding with negative health outcomes, the previous approaches discuss the preventative benefits of breastfeeding. In the case of formula risk frames, however, activists are explicit in their construction of

formula feeding as "dangerous" method of infant feeding and directly connect formula feeding with undesired health outcomes. In other words, formula risk frames are the mirror image of baby-saving frames. For example, in this Infant Feeding Action Coalition (INFACT) statement, Canadian activists argue that:

> Increased consumption of infant formulas is linked to higher rates of infant and childhood illness such as gastrointestinal, respiratory and ear infections; increased chronic illness including juvenile diabetes, asthma and allergies, as well as childhood cancers. Adults who were formula fed during infancy are at higher risk from obesity and heart disease (INFACT 2004f).

Although this argument addresses similar infant risks that were mentioned in the baby-saving frames, this approach is more explicit in stating that the *cause* of these negative health outcomes is feeding a child formula rather than breast milk. Therefore, activists are striving to construct formula feeding as a risky behavior so that women may interpret bottle-feeding as putting their child "in danger."

In fact, the United States Department of Health and Human Services (US-DHS) worked with the Ad Council to develop a public service campaign that "highlights the consequences of formula feeding" (Health and Human Services 2004). These ads featured visibly pregnant women riding mechanical bulls and log rolling and asked the audience, "You wouldn't take risks before your baby was born…Why start after? Babies were born to be breastfed" (Health and Human Services 2004). In this case, these activists connect the risks of formula feeding to these obviously dangerous activities. This strategy not only plays off common sense, but also the culture of intensive motherhood in which women are expected to make every possible effort to raise supremely healthy and well-adjusted children and go the extra mile not to put their children at risk of any dangers.

Mother's Health Frames

In some instances, the focus of these activists' arguments regarding the benefits of breastfeeding moves from the baby to the mother. Although they are less common than baby-saving arguments, 25 percent of the sample addressed the mother's potential benefits from breastfeeding. Similar to the baby-saving arguments, with this approach we see most of the focus on the *physical* health of women. This US-DHS brochure spells out some of these benefits:

> Breastfeeding—Best for mothers: promotes closeness and bonding of mother and baby; helps the uterus to return to its normal size after birth; helps to control bleeding after birth; helps to protect against breast cancer and ovarian cancer; helps to keep bones strong; helps with weight loss after birth (PD 237).

Although the first benefit listed is emotional, the remaining five benefits listed all emphasize the physical benefits mothers may experience from breastfeeding. By focusing mostly on the potential physical benefits, this approach, like some of the baby-saving frames, taps into the cultural obsession with optimal health and the reduction of any unhealthy risks. In contrast to many of the baby-saving frames, however, the mother's health approach actually recognizes mothers as participants in the breastfeeding relationship.

Like the debatable evidentiary support for many of the baby-saving claims, these mother's health frames are also controversial. For example, although some of these reports cite research supporting the claim that breastfeeding mothers lose more weight than non-breastfeeding mothers (c.f., Brewer 1989), in a study on the weight loss differences between lactating and non-lactating mothers, researchers found that

"Nonlactating women lost whole-body, arm, and leg fat at a faster rate than did lactating women between two weeks and six months postpartum" (Wosje and Kalkwarf 2004:423). Therefore, even the often-purported claim that women should breastfeed in order to lose their pregnancy weight more efficiently is a contentious argument.

A less common approach to enhancing mothers' health through breastfeeding is seen in the following statement by INFACT. They write, "In addition to a healthier and better-adjusted baby, the hormones released by breastfeeding help you [the mother] sleep better" (INFACT 2004d). In this case, the argument addresses a simple and practical benefit of breastfeeding for mothers—the ability to get more rest. This benefit is an advantage that mothers could experience in the "here and now" rather than in the future or through the *absence* of an illness experience. However, the above INFACT quote also demonstrates how mothers' benefits are nearly always highlighted as secondary, where the primary benefit is the health of the child. In this case, the sleeping benefits for mothers are mentioned only after the importance of having a "healthier and better-adjusted baby" (INFACT 2004d).

If they are mentioned at all, benefits to the mother are almost always listed after benefits to the baby. For example, in the US-DHS quote above, the authors first list the importance of bonding as physically mediated through the mothers' body in the act of breastfeeding, rather than a benefit experienced solely by the mother. Secondly, in the full text of this document, the "Benefits to Mother" section comes beneath the "Benefits to Baby" section. Therefore, even in this modern approach to persuading women to breastfeed by addressing the benefits a mother may receive from the experience, the focus is still primarily on the health of the child.

One of the main arguments used by early maternalists (circa 1950s), particularly those involved with La Leche League (LLL), was that breastfeeding was good for mothers because of the emotional and spiritual connection they could have with their children and other mothers. However, as medical and governmental organizations became more involved in breastfeeding activism, throughout the 1970s and beyond, any benefits to the mother faded from the discourse. Instead, their arguments focused almost exclusively on the benefits to the infant. The reintroduction of these mother's health frames did not begin again until the early 2000s, and in these more contemporary arguments, the focus is often on the physical health of the mother rather than any emotional or spiritual benefit she might receive from the act of breastfeeding. Such a change demonstrates the cultural shift towards more scientific arguments and a rejection, particularly by government sources, of non-rational, non-scientific arguments to persuade mothers to breastfeed.

Therefore, most of the arguments that articulate the benefits of breastfeeding for mothers focus on reducing the risks of postpartum complications with an occasional mention of mothers' ability to better bond with their children through breastfeeding. They specifically address women's physical health regarding their risk of future disease (i.e., cancer) as well as a way to improve their immediate health (e.g., weight loss and improved sleep).

Therefore, baby-saving frames, formula risk frames, and mother's health frames make up the preventative health approach to breastfeeding activism. In these approaches, activists construct formula feeding as a dangerous alternative to breastfeeding. They are

likely to suggest that breastfeeding offers protection from a variety of unwanted health outcomes. I now look at another approach to persuading mothers to breastfeed.

Social Responsibility Frames

In contrast to the preventative health approaches, the social responsibility framing strategies focus on the importance of social support for mothers to be successful breastfeeding. Although mothers are still the targets for many of these messages, the focus of the arguments moves from the embodied experience of breastfeeding by mother and child to the social responsibilities and communal consequences of breastfeeding. Therefore, the diagnostic causes of this social concern remain the same—it is problematic for women to not breastfeed. However, the effects of this problem shift from negative health outcomes to negative social outcomes. In the case of social good framing, the negative effect is that women are not fulfilling their social responsibility to their community. In the case of rights framing, the negative effect is that women are experiencing an injustice.

Both of these approaches draw on liberalism as a cultural resource to resonate with their audience. Drawing on liberal political theory (Okin 1989; Rawls 1971), these two framing strategies reference the resonant notions of equality, democracy, and justice. The frames in this category emphasize women's need for inclusion in the ideals of liberal democracy as well as her responsibility to contribute to that democracy. Each of these will be discussed below.

Social Good Frames

The next framing strategy in the breastfeeding movement, used in 15 percent of documents, is the "social good" approach. These arguments draw on a culture's sense of community and the ways in which the actions of one person can influence and affect the actions of someone else. In this case, social good frames address either the importance of a mother's community in providing support for her breastfeeding or the ways in which a breastfeeding mother affects her community at large. According to this approach, breastfeeding is most easily accomplished with communal support while at the same time breastfeeding provides a social good to the rest of society. There are two types of communal framing strategies, including an emphasis on a collective responsibility to support breastfeeding mothers and a mother's social responsibility to breastfeed for her community.

Collective Responsibility to Support

The first kind of social good framing speaks directly to communities, rather than mothers, and argues that women need communal support for success in breastfeeding. For example, a Health Canada (Canada's national health care agency) advisory notice reads, "Active public health, hospital, community and workplace support of breastfeeding will increase initiation rates and duration of breastfeeding" (Health Canada 2005). This piece goes on to provide specific suggestions for increasing the ease of women's experiences with breastfeeding, such as "antenatal and postnatal counseling about the principles and practice of breastfeeding…[and] provid[ing] more community-based programs supporting breastfeeding families as the length of hospital stays decreases"

(Health Canada 2005). These arguments demand not only informal public support for breastfeeding mothers, but also very structured and specific methods of breastfeeding support such as counseling and community support groups. Such arguments suggest that the success of mothers' breastfeeding efforts is not solely dependent on their own volition but also on the efforts and support of the community in which she lives. These arguments remove some of the responsibility of breastfeeding from a mother and place it on her community such that communities *should* help make the experience of breastfeeding an easy one.

Social Responsibility to Breastfeed

Another type of social good frame discusses how breastfeeding is not just best for mother and baby, but also best for the community at large. These arguments, which are directed at mothers, push our attention away from the ways in which breastfeeding benefits mothers and babies and focuses instead on the ways in which breastfeeding can benefit the community. The issues that are most often discussed in this approach are how breastfeeding benefits the economy, healthcare and the environment. For example, in the following INFACT sheet we see a specific reference to breastfeeding as benefiting society. It reads:

> For the family and community, breastfeeding: reduces costs to families; protects the environment; improves health and wellbeing of our population; decreases health care costs (fewer physician and hospital visits); requires fewer resources and staff time in hospitals when mothers and babies room-in together; contributes to long-term health care savings; improves productivity and reduces absenteeism among breastfeeding mothers as a result of healthier children (INFACT 2004f).

This kind of argument encourages mothers to breastfeed because of the many benefits that breastfeeding offers to their community. A push to understand breastfeeding as a social concern, greater than the experience of the individual, is also evident in the following argument by the Canadian Pharmacists Association (CPA). They state that "increased breastfeeding rates should result in a healthier Canadian population and lead to lower health care costs" (CPA 2001). These two arguments draw on issues that resonate with the public as contemporary social problems (e.g., healthcare, the economy, and the environment) and by doing so, these arguments help make the issue of breastfeeding larger than an individual concern. Like the previous method for social good framing, these frames lean towards a belief that breastfeeding is not simply an individual decision but rather a communal, or social problem. Such an approach may make a mother feel a social responsibility to breastfeed if she is being encouraged to do so not simply for her and her children's health but also for society at large.

A social good approach discourages individual-focused thinking and encourages a more communal perspective by pointing out the ways in which one's actions affect the experiences of others. In this case, such a position notes how social support for breastfeeding is likely to make mothers' experiences breastfeeding more enjoyable. Furthermore, this perspective encourages mothers to consider the consequences of their infant feeding decisions on the community at large.

Rights

The rights strategy was less common than the previous approaches, used in 13 percent of the documents. These arguments typically address a woman's right to breastfeed and right to be structurally supported while breastfeeding (e.g., maternity leave, breastfeeding stations at work, public breastfeeding support). Although the goal of these arguments remains to increase breastfeeding rates, this approach encourages breastfeeding by persuading mothers to feel they have experienced an injustice if they are not supported in their efforts to breastfeed. This approach seeks to remind both women and their social community that mothers should experience a cultural environment that supports breastfeeding and the failure of that experience is unethical.

Examples of the rights framing strategy include the "anytime, anywhere" argument. Several INFACT information sheets read: "[R]emember, you have the right to breastfeed anywhere, anytime" (INFACT 2004c) and "Breastfeeding is a fundamental human right" (INFACT 2004a). Indeed, the breastfeed "anytime, anywhere" argument is part of a national campaign by the Canadian government, which argues that women have the *right* to breastfeed "anytime, anywhere."

Other rights arguments demand that workplaces provide adequate structural support for breastfeeding mothers (e.g., breaks to breastfeed or pump, onsite childcare, a private and sanitary place to pump and store milk). For example, the Canadian Commission for Human Rights argues that, "Women should not be disadvantaged in services, accommodation or employment because they have chosen to breastfeed their children" (Toronto Public Health 2007). In Canada, this commission helps detect and prosecute human rights violations, suggesting that businesses have a legal responsibility

to support breastfeeding mothers. Although only a few states have passed this kind of legislation, the USBC argues that more legislation is needed to protect breastfeeding mothers who "have the right to breastfeed in any public or private place where they have the right to be" (USBC 2003). They encourage breastfeeding activists to demand an increase in their local legislation supporting breastfeeding mothers because "the goal of all breastfeeding legislation is to encourage more women to choose breastfeeding and to prevent harassment" (USBC 2003).

These arguments are likely to encourage mothers to breastfeed because if women understand and/or are reminded that they have a *right* to breastfeed, they may feel empowered to do so. This response could develop because they do not expect discrimination while nursing in public, but rather, feel communal support in their decision to breastfeed. Furthermore, this approach motivates women to breastfeed by constructing the behavior as something desirable and worth fighting for.

These are the frames used in Canada and the U.S. as part of breastfeeding activism. Next, I examine how these frames exhibit embodied characteristics and do boundary work.

II. Embodiment

In Chapter Two, I examined the ways in which the breastfeeding movement functions as an embodied health movement. Scholars have argued that embodied health movements make the body central to the social movement by utilizing the embodied illness experience to legitimate their activities (Brown et al. 2004). In the case of breastfeeding activism, embodiment is conveyed through the *risk* of disease rather than

the actual experience of an illness. Embodiment is demonstrated in two ways; first of all, the health benefits that are purportedly experienced by breastfeeding exist within the bodies of mothers and babies. Secondly, because mothers are constructed as ultimately responsible for the healthiness of their children, they, by proxy, embody the risk of unhealthiness for their children.

The first way in which embodiment is articulated in breastfeeding arguments, through the health benefits of breastfeeding, is clearly visible in breastfeeding activists' most popular approach, the baby-saving frames. This strategy constructs infants as embodying risk, describing their future well-being as in jeopardy and breastfeeding as a safeguard from the dangers of disease and illness. For example, in the baby-saving arguments, activists discuss the many diseases that breastfeeding helps ward off, including asthma, chronic ear infections, diabetes, etc. These threats to a child's physical health makes the prevention of these dangers an embodied experience for infants.

This strategic focus on the embodied, physical health of a person is also visible in the mother's health frames. These frames address how various risks to women's health are reduced through the physical act of breastfeeding, including the risks of contracting ovarian cancer, breast cancer, and osteoporosis. As mentioned above, these arguments are relatively new in the breastfeeding movement. Previously, the mother's role in the breastfeeding relationship was often ignored as most of the focus was on advancing the health of the infant. Therefore, these mothers' health frames re-embodied women into the breastfeeding relationship by bringing women's bodies into focus. Rather than ignoring the mother's embodied experience of breastfeeding by constructing her as

simply a provider of milk and a source of protection, these arguments reincorporate mothers' bodily experiences into the dominant discourse of breastfeeding.

The second way in which embodiment is demonstrated in breastfeeding arguments is in the targeting of breastfeeding frames. Most of the breastfeeding framing strategies are directed at mothers with the expectation that women should take every precaution in their effort to protect their children from unnecessary disease. Therefore, although the baby's (future) health is the focus of most breastfeeding frames, mothers are the recipients of these arguments. It makes sense that mothers are the targets in two ways. First of all, only mothers can physically provide the desired act of breastfeeding a child. Therefore, it is mothers (via their bodies) who perform the embodied health behavior that prevents children from facing the purported health risks. Secondly, as previously discussed, theorists have demonstrated that in the contemporary cultural climate U.S. and Canadian mothers hold, almost exclusively, the responsibility for raising healthy, well-adjusted children. Particularly for white middle class women, "good" motherhood has become a condition of successful femininity and the cultural pressure to mother intensively demands that mothers make any sacrifices necessary for their children's wellbeing (Hays 1996). Therefore, women embody the consequence of an unhealthy child as a reflection on their success as mothers. This is particularly apparent in arguments that either equate breastfeeding with a kind of love for one's child or construct formula feeding as a dangerous behavior.

III. Boundary Work

Another distinctive characteristic of embodied health movements is the boundary work they do. As discussed in Chapter Two, boundary work can be identified in a variety of ways. First of all, boundary movements actively work to "demarcat[e] good science from bad science" (Brown et al. 2004:63). In the breastfeeding movement, we see this when activists critique research supported by infant formula companies, such as Nestle. For example, in the following INFACT flier, advocates use the formula risk framing strategy to contend that Nestle committed scientific fraud. In this piece, the authors argue that Nestlé funded research to demonstrate that one of its formula brands was hypoallergenic and "could reduce atopic symptoms in infants at risk…similar to [or] even better than those seen exclusively in breastfed infants" (INFACT 2006). However, the research, though authored by an acclaimed researcher and published in a respected medical journal, was fraudulent. In light of these findings, INFACT activists argue that this scandal "reveals the inherent problems with corporate funded medical research" and conclude that "Formula feeding is expensive and carries risks of additional illness and death" (INFACT 2006). This document uses formula risk framing to persuade women not only that formula feeding is a risky feeding method, but also that the claims made by formula companies cannot be trusted. Furthermore, these arguments are defining a particular kind of research as "bad" science, research that is funded by formula companies who have a monetary motivation to skew their results. By negotiating good science from bad science, this kind of argument does boundary work within the movement.

Another example of breastfeeding activism performing boundary work is the blurring of boundaries between experts and lay people. This kind of distortion occurs when lay activists "arm themselves with medical and scientific knowledge…[and work] with scientists and medical experts to gain a better level of understanding the science" (Brown et al. 2004:64). Members of LLL have effectively demonstrated this kind of boundary breaking. La Leche League began as a group of mothers who could support each other through the lived experiences of motherhood. However, as they have increasingly drawn on baby-saving frames, they have developed a sense of medical expertise regarding the benefits of breastfeeding. In fact, current arguments by LLL are saturated with citations for breastfeeding recommendations by major medical associations and citations of recent medical studies that demonstrate the medical benefits of breastfeeding. For example, in the following media release, LLL argues that

> human milk is the gold standard of infant nutrition…according to the American Academy of Pediatrics' statement about breastfeeding, 'From its inception, the American Academy of Pediatrics has been a staunch advocate of breastfeeding as the optimal form of nutrition for infants' (LLL 2006).

The authors go on in this piece to cite research projects that have medically demonstrated some of the benefits of breastfeeding (e.g., helping IQ, preventing obesity). Furthermore, LLL has teamed up with government and medical organizations such that they are referenced by other major organizations as excellent sources of support. For example, in a handout about breastfeeding from the US-DHS, they list LLL's toll-free hotline as an important reference for mothers to consider if they are experiencing breastfeeding troubles (Shealy et al. 2005). Therefore, LLL has gained an appreciated level of

expertise with regard to breastfeeding information and support and has therefore blurred the boundary between scientific and lay experts.

The final way in which we can see boundary crossing evident in the breastfeeding movement is when activists consistently cross boundaries that other movements are less successful crossing. We see this boundary work occur when activists strategically utilize resonant frames from other social arenas in order to be persuasive to a broader audience. In the case of breastfeeding activism, this tactic is most visible when actors use the "social good" framing strategy in which they draw on arguments about the communal benefit of breastfeeding. For example, this framing strategy argues that breastfeeding is good for the community because it is less stressful on the environment than formula feeding. A LLL (2002) media release states:

> What is the one thing only mothers can do to help reduce landfill waste, preserve valued energy, and help prevent deforestation? Breastfeed their children…human milk remains the ultimate natural renewable resource and perhaps the most overlooked way of helping to create a healthier planet.

Similarly, INFACT argues that "Breastmilk is the most ecologically sound and complete food available to infants. It is the foundation of food security for all infants and young children and is one of the world's most valuable renewable natural resources" (2004b). This environmental claim taps into growing concerns and pulls from the environmental movement's influence. Therefore, despite breastfeeding and environmental concerns being seemingly unrelated, breastfeeding activists have crossed traditional movement boundaries and utilized the resonant claims of environmentalism to encourage women to breastfeed.

Another example of this kind of boundary work is also evidenced in the framing strategies of breastfeeding activists as they work to make breastfeeding a human rights issue. The Breastfeeding Committee of Canada (BCC), for example, has actively campaigned to align the rights of women to breastfeed in public spaces with support for other human rights issues, including banning employment discrimination or service discrimination based on race, creed, religion, or nationality. This strategy crosses boundaries as it brings together the encouragement for women to breastfeed their infants with a sense of entitlement for breastfeeding mothers to nurse in public. Furthermore, discussions of human rights very often involve the promotion of legal remedies for the given violation. Therefore, activists are drawing authority from the language of human rights in order to encourage mothers to breastfeed as well as suggest a legal threat to businesses and the community at large against those who do not support and protect women's right to breastfeed.

IV. Conclusion

Each of these approaches to persuade mothers to breastfeed has crossed some kind of traditional movement boundary. This ability, to simultaneously contest and ally with particular scientific authorities, to redefine the meaning of expert, and to connect the physical and embodied experience of breastfeeding and being breastfed and reconstruct it as a social good, are all ways in which the breastfeeding movement does boundary work. This kind of boundary work is one of the characteristics that makes embodied health movements distinctive.

For the remainder of this chapter, I explore variations in the use of these framing strategies. As mentioned earlier, I begin "at the top" and first look at differences in framing between activists in the U.S. and Canada and examine cultural explanations for this variation. Next, I move down to the organizational level and explore how lay, medical, and government activist organizations compare in the use of particular framing strategies. Finally, I examine differences both across organization and geographical location.

Frames in the U.S. versus Canada

In this section, I compare the framing strategies used by Canadian and American breastfeeding activists. Table 3.2 illustrates the use of each type of frame in the respective cultural setting. These findings advance our understanding of the ways in which "place" expands and constrains the cultural resources from which arguments can be drawn. I begin by examining similar framing strategies in the U.S. and Canada. Next, I identify differences in framing strategies by Canadian and U.S. activists and connect those differences to larger cultural variations. I conclude with potential consequences for these different framing strategies with regard to interpretations by the main intended targets—mothers.

TABLE 3.2: PERCENTAGE OF DOCUMENTS USING PARTICULAR FRAMES WITHIN EACH COUNTRY			
Framing Strategy	*United States (N=100)*	*Canada (N=100)*	*Total (N=200)*
Baby-saving Frame	68% (68)	50% (50)	59% (118)
Formula Risk Frame	27% (27)	32% (32)	30% (59)
Mother's Health Frame	26% (26)	23% (23)	25% (49)
Social Good Frame	10% (10)	19% (19)	15% (29)
Rights Frame	7% (7)	18% (18)	13% (25)

I. Similar Framing in Canada and the U.S.

In their campaigning efforts, breastfeeding activists in the U.S. and Canada have drawn on some similar arguments, including baby-saving frames, mother's health frames, and formula risk frames. It is likely that the high usage of these frames in both Canada and the United States underscores similar discursive opportunity structures that encourage the use of these kinds of approaches. As discussed in the literature review, the beliefs, ideologies, and characteristics of a particular environment selectively affect which frames are most likely to resonate with a given audience (McCammon et al. 2007). Therefore, frames that are consistent with dominant cultural discourses are likely to resonate while those that contradict them will be considered radical (Ferree 2003). In order to be successful, movement actors must be strategic as they construct their frames, tapping into the cultural ideologies of their setting (Benford and Snow 2000). Given that many of the cultural conditions in the U.S. and Canada are similar, it makes sense that some of the framing strategies used in each country were similar. Here I examine how a culture of increasing medical authority and the construction of risky childhood provide

comparable discursive opportunities for breastfeeding activists in the United States and Canada.

Medical Authority

Both U.S. and Canadian activists focused most of their attention on the medical benefits of breastfeeding. As activists address the ways in which infants and mothers can physically and psychologically benefit from breastfeeding, they cite medical research that demonstrates these findings. In particular, activists drew on the research endorsed by and recommendations made by the major pediatric medical associations: the American Academy of Pediatrics (AAP) and the Canadian Paediatric Society (CPS). Both of these organizations recommend exclusive breastfeeding for the first six months of life and encourage breastfeeding to continue for up to two years and beyond (Boland 2005; AAP 2005). Furthermore, both of these organizations actively promote breastfeeding and work with the government on initiatives to increase breastfeeding initiation and duration rates through public campaigns, increased medical research, and policy initiatives.

As representatives of the institution of medicine, the AAP and the CPS have similar licensing and educational practices and each country has awarded their respective organization substantial lobbying power (Maioni 1999). The gradually growing influence of these organizations has paralleled a more general increase in medical authority during the twentieth century. Both the U.S. and Canada have increasingly awarded power to the institution of medicine—the power to define and regulate social behavior (Conrad 1992; Foucault 1984; Zola 1972). Therefore, we have seen an increase in public health recommendations and other biopolitical efforts to encourage particular

health beliefs and behaviors, particularly in the last fifty years. These include dietary and nutrition recommendations, anti-smoking campaigns, and now recommendations regarding breastfeeding, each funded by the U.S. and Canadian governments and sponsored by major medical associations.

With regard to pregnancy and childbirth, this rise in medical authority emerged and solidified by the mid-twentieth century (Conrad 2008). Given this level of authority, breastfeeding activists have increasingly drawn on that discursive opportunity. In both spaces (i.e., the United States and Canada) they have used scientific authority to make persuasive claims, impressing on mothers the medical benefits of breastfeeding and citing the AAP and CPS as validating sources. We see this, first of all, in the official policy statements in which these organizations recommend breastfeeding for at least six months and to continue up to two years. However, we see the influence of these organizations reinforced as other groups cite the AAP and CPS as sources of medical authority. For example, Jack Newman has a breastfeeding handout that reads, "the Canadian Paediatric Society, in its latest feeding statement acknowledges that women may want to breastfeed for two years or longer" (Newman 2003). Likewise, a committee for the US-DHS argues that breastfeeding is important because "According to the American Academy of Pediatrics (AAP), breastfeeding can help reduce the occurrence of diarrhea, ear infections, respiratory infections, Botulism and urinary tract infections" (2008). Baby-saving frames that emphasize the medical benefits of breastfeeding for children and mothers' health frames that emphasize the ways in which mothers medically benefit from breastfeeding take from and contribute to the general medicalization of the United States and Canada.

Risky Childhood

In addition to drawing on medical arguments more generally, activists in both the U.S. and Canada used the baby-saving frames more than any other approach. This similarity highlights an additional resource present in both spaces—the cultural belief in "sacred childhood" (Hays 1996). This argument suggests that in recent history, children have been constructed as innocent and pure and deserving of all necessary protection to maintain that purity for as long as possible (Zelizer 1994; Hays 1996; Douglas and Michaels 2004). This interpretation of childhood contributed to the development of intensive motherhood, where the expectations of "good" motherhood began to include the supreme protection of children's health. As Lupton (1999b: 82) writes:

> More so than ever in the past pregnancy is portrayed as a series of events that are located within a sphere of rationalist control. Producing a 'perfect' infant is seen to be at least partly a result of the woman's ability to exert control over the body, to seek and subscribe to expert advice and engage in self-sacrifice for the sake of her fetus.

We see these particular expectations of motherhood play out in the rapid increase in production of and reception of mothering manuals and recommendations from "experts," growing especially from the 1970s onward (e.g., *Dr. Spock's Baby and Childcare* (Spock 1946), *What to Expect when You're Expecting* (Murkoff and Mazel 1984), and *The Baby Book: Everything You Need to Know About Your Baby from Birth to Age Two* (Sears et al. 1993)). Each of these efforts to advise and control the way in which mothers prepare their fetuses and raise their children contributes to the construction of "risky childhood" (see also Best 1990). It is in this socio-cultural context of expert-guided recommendations and pressure to protect the sanctity of childhood that

mothers are making decisions about infant feeding and that activists are working to persuade mothers to breastfeed.

This construction of risky childhood in both the U.S. and Canada suggests similar discursive opportunities for a strategic focus on children's health. We see this focus in the baby-saving frames more than in any other framing strategy. In these arguments the health of the child is paramount and children are constructed as needing protection through the act of breastfeeding. Formula feeding is constructed as dangerous to both the physical health of the child, drawing on the authority of medicine, as well as the relationship between child and mother, such that a failure to breastfeed affects their bonding abilities. Arguments focused on the dangers of formula feeding and the benefits of breastfeeding are likely to be resonant in this cultural environment given these pressures to achieve a particular version of "good" motherhood. Therefore, a second discursive opportunity that exists in both the United States and Canada is the construction of risky childhood.

Similar framing strategies by activists in the United States and Canada can be explained by the similar discursive opportunities of medical authority and the construction of risky childhood. These two cultural resources provide activists with the language and framing strategies that are more likely to resonate with the target population.

II. Different Framing in Canada and the U.S.

While similar framing strategies in the U.S. and Canada reveal comparable discursive opportunities in each country, not all of the strategies employed were similar across cultural contexts. In fact, Canadian activists were more likely to draw on rights and social good framing than U.S. activists ($P < .05$ using simple t-test). It is likely that this variation is a reflection of cultural differences such that some framing strategies are more likely to resonate in a given environment while others are more likely to be considered too radical to effectively persuade a general audience. As Ferree (2003) explains, with regard to discursive opportunity structures, discourses are institutionally anchored and "provide a gradient of relative political acceptability to specific packages of ideas" (p. 309). In the case of breastfeeding activism, different kinds of structural supports available to breastfeeding mothers will likely affect the kinds of arguments that resonate with a given audience (and visa versa as well).

Canadian governments and social services provide much more structural support for breastfeeding mothers than do their United States counterparts. For example, Canada provides, by law, 50 weeks paid maternity leave for mothers, whereas the U.S. provides 12 weeks unpaid leave that is covered as part of sick leave. Furthermore, Canadian provincial insurance often covers the cost of midwives in addition to having lactation consultants available in most hospitals. These medical professionals not only provide ample support for mothers in general but are also considered experts in helping mothers through breastfeeding challenges. In contrast, mothers are responsible for buying their own medical insurance and the coverage they are offered and/or can afford affects the kinds of medical benefits that are covered. In fact, there are many insurance plans in the

U.S. that refuse to cover any costs of maternity care. Therefore, in Canada we not only see activists encouraging mothers to breastfeed, but we also see a federalism that offers the necessary support structure for mothers to do so with ease. In contrast, we see a neoliberal attitude in the United States (which will be discussed in further detail below), especially with regard to health care, such that most of the burden of being and staying healthy is borne by individuals. In other words, despite government recommendations regarding prenatal and maternal behaviors, maternal care in the U.S. is an individual responsibility with very little government contribution. It is within these structural contexts that the discourses surrounding breastfeeding are anchored.

Rights Frames

Eighteen percent of Canadian documents (while only seven percent of U.S. documents) drew on the rights framing strategy. As mentioned earlier, one component of the national, government-sponsored campaign in Canada is the argument that women have the right to breastfeed anytime, anywhere. In fact, Health Canada, the national healthcare organization, worked with public health organizations to develop and adopt an official policy on breastfeeding. The statement, "Pregnancy and Breastfeeding: Your Rights and Responsibilities," is publicly available online and advises women that:

> You have the right to breastfeed a child in a public area. No one should prevent you from nursing your child simply because you are in a public area. They should not ask you to 'cover up,' disturb you or ask you to move to another area that is more 'discreet.' (Toronto Public Health 2007)

If any of these rights are violated, the statement encourages women to contact the Ontario Human Rights Commission. Furthermore, Health Canada also distributed the following

sticker (Figure 3.1) to businesses so that they might demonstrate their support for breastfeeding mothers.

Figure 3.1: Health Canada Breastfeeding Friendly Sticker

In this promotional campaign, women are encouraged to feel comfortable breastfeeding. It draws on the ideology that women have the *right* to breastfeed and the right to do so with respect and without interference, even in public spaces.

In the rare circumstances in which a rights framing strategy was used by U.S. activists (argument present in seven percent of documents), it was usually directed at business owners rather than the general public. The USBC is a government-sponsored group that began in 1995 as a group of independent breastfeeding advocates but became endorsed by the U.S. government and included governmental voting members in 2004. The group is now composed of state, medical, and lay activists and is one of the few U.S. groups that uses a rights framing strategy. This group has worked to help legislators and activists pass laws in states to support a woman's right to publicly breastfeed. In an issue

paper outlining current state breastfeeding legislation, the USBC articulates that "[Breastfeeding] legislation is most effective when it clearly specifies that women have the *right* to breastfeed in any public or private place where they have the right to be, even if there is exposure of the breast" (USBC 2003, emphasis in original). Although the targets of these statements are not the general public, but rather legislators and activists, other activist organizations, such as LLL, cite such government-sponsored information to motivate mothers. However, the use of this strategy is still quite rare by U.S. breastfeeding activists.

In her comparison of rights framing in the U.S. and Canada with regard to same-sex marriage activism, Smith (2007) argues that:

> In the USA, the human rights frame is under siege and caught up in a dynamic of movement and counter-movement politics while, in Canada, the human rights frame is dominant and increasingly identified with both Quebec and Canadian nationalism, although in different ways. (p. 18)

This finding suggests that the discursive opportunity for rights framing differs in each country such that this strategy has more authority in Canada than in the United States. As this kind of argument takes a "dominant position" it becomes more resonant to the intended audience and therefore, is more likely to be strategically drawn upon by social movement activists. However, many social movements in the U.S. have drawn on a version of the rights frame (cf. McCammon et al. 2007), making it surprising that American breastfeeding activists have not tapped into that discursive language as much as those in Canada.

Another explanation for why U.S. breastfeeding activists have not utilized rights framing is because of the unique circumstances of health social movements. Breastfeeding is actively promoted in the U.S. and Canada by a cooperation of lay

activist, medical, and government organizations. In both countries, a rights framing strategy is likely to be critical of government organizations for not providing the necessary structural supports for mothers to successfully breastfeed (e.g., maternity leave, breastfeeding and/or pumping stations at work, laws protecting public nursing, onsite childcare). However, the Canadian government has already responded to many of these demands and provided support and protection for breastfeeding mothers. When Canadian activists are using this argument, they are reinforcing the importance for mothers to recognize that their ability to breastfeed is a protected right.

In contrast, the U.S. government, while participating in encouraging women to breastfeed, has been resistant to providing protected supports for breastfeeding mothers, in addition to other related issues. As mentioned above, the U.S. maternity leave policy only guarantees 12 weeks of unpaid leave from work, and only a few states[8] have increased this provision. However, there remain few laws protecting mothers who are nursing in public nor are there requirements for businesses to provide protections that would make breastfeeding more compatible with an American mother's lifestyle. Therefore, although many American activists have strongly relied on the rights language in their framing strategies for other movements, this case is particularly complicated. There is power in the movement by having governmental recommendations about breastfeeding. Therefore, lay and medical activists may not want to risk the authority that is leveraged by challenging the government to provide support for breastfeeding mothers. Thus, although the discursive opportunity exists for rights framing in general, with regard

[8] California, Connecticut, Hawaii, Iowa, Louisiana, Maine, Massachusetts, Minnesota, Montana, Oregon, Rhode Island, Tennessee, Vermont, Washington

to breastfeeding activism, U.S. activists have not been able to draw on the language arguing women have a right to breastfeeding support.

Neoliberal Culture

Another way in which the U.S. and Canadian activists differ in their breastfeeding framing strategies is the use of social good frames. Like the rights frames, these community frames are more likely to be used in Canada than in the U.S (present in 19 percent of Canadian documents and only 10 percent of U.S. documents). These efforts encourage mothers to breastfeed because doing so contributes to the good of society. They argue that breastfeeding is better than formula feeding with regard to the environment (with less waste in the construction and disposal of formula products) and the economy (because it is believed that breastfed babies are healthier and therefore parents will miss less work to take care of a sick child). In this case, activists encourage mothers to breastfeed for a more efficient and productive population. These kinds of recommendations represent biopolitical efforts of organizations to control people's health beliefs and behaviors for a greater social good and a difference in neoliberal culture.

As Foucault (2008) describes in his lectures, *The Birth of Biopolitics*, neoliberalism in the U.S. is focused on deregulation and de-emphasis of governmental intervention while focusing on increasing economic power through competition. The goal of a neoliberal society is to maximize productivity. As described in Chapter Two, biopolitics is the discursive construction of "good" or "bad" bodily behaviors that affect one's productive capacity. Therefore, while neoliberal governments prefer a hands-off approach with regard to the economy and welfare, they create policies that suggest ways

in which people can regulate themselves (e.g., healthy behaviors such as diet and exercise) in order to make themselves more productive and competitive in the economic market. Given the highly individual (versus social) nature of the social good discourse, it makes sense that arguments focusing on the social good of breastfeeding are rarely used in the United States.

In the occasional instance when U.S. activists did draw on social good frames, the pieces were rarely directed at mothers but rather at activists or employers. See for example the following statement by the AAFP (2008), which states:

> When advocating for breastfeeding issues related to insurance coverage and workplace changes, the economic benefits of breastfeeding are essential issues. Several studies have shown substantial increase in cost to families, communities, health care systems, and employers when babies are not breastfed.

In this instance, the AAFP addresses how activists should approach workplaces and insurance companies when campaigning for more breastfeeding support. They encourage advocates to note the financial benefits that companies and society-at-large may experience by supporting a breastfeeding mother. However, even this argument does not take the next step of encouraging society or mothers to think about breastfeeding as a communal issue with responsibility resting on both sides.

In other variants of the social good framing strategy, Canadian activists reinforce the importance of communal support to encourage mothers to provide this social good. For example, they articulate demands for specific legal and logistical remedies that could help make the experience of nursing, especially in public, more convenient. Also, these arguments encourage the audience to regard breastfeeding as the normal and expected social behavior for the way mothers feed their infants. As stated previously, by

expecting mothers to breastfeed because it is a *normal* behavior, the public is more likely to be prepared to support and handle a mother nursing in public (as well as provide sanctions against mothers who do not breastfeed). This approach to encouraging mothers to breastfeed through the promised support of her community was non-existent in the U.S. activist literature.

The variation in these framing strategies suggest differences in the cultural context such that neoliberalism is much more intense in the U.S. than in Canada. In the United States, although the government has involved itself in breastfeeding activism (e.g., official breastfeeding recommendations), they have provided few, if any, structural supports to make that goal a reality. Rather, we see a neoliberal approach such that women are responsible for their own health and the health of their children in spite of any external forces that may affect that reality. The approach in the U.S. suggests that breastfeeding is very important at the individual level, in order to increase the healthiness of the general population. However, the government does not provide structural supports that could assist mothers in their efforts to successfully breastfeed. Thus, despite biopolitical efforts to control people's health beliefs and behaviors, the logistics of making those changes a reality are a responsibility left to individuals (usually mothers).

IV. Conclusion

As illustrated above, there are several differences in the breastfeeding framing strategies between the U.S. and Canada. In particular, Canadian activists are much more likely to draw on rights and social good frames than activists in the U.S. Also, Canadian arguments are often focused on changing the structural constraints and supports for

breastfeeding and expanding the responsibility of breastfeeding from an individual experience to a communal issue. By arguing that breastfeeding should be understood as a "rights" and "social good" issue, Canadian activists have helped frame breastfeeding as a *social* rather than individual problem. The Canadian actors make this shift by illustrating the ways in which the decision to breastfeed is constrained by structural support systems and the impact that this decision can have on society-at-large. This concept of communal effort is further evident in the structural support that Canadians provide to breastfeeding mothers, such as paid maternity leave, and to the community in general, such as universal healthcare.

In contrast, U.S. activists are not very likely to use a rights or social good framing strategy, keeping the focus of their breastfeeding arguments on the individual decision and responsibility to breastfeed. They are much more likely to employ baby-saving frames than any other type of argument, an approach strongly tied to gender and maternal expectations in American culture. Women are held, almost exclusively responsible for all childcare duties, and because successful womanhood is tied into successful intensive mothering, the accepted demands for childrearing are quite high, therefore, it is the duty of American mothers to do all they can to make their baby as happy and healthy as possible. Furthermore, although the U.S. government has actively participated in this breastfeeding activism, they have provided few to no structural supports to make this goal a reality. Rather, we see a neoliberal approach such that women are responsible for their own health and the health of their children in spite of any external forces that may affect their ability to succeed. These cultural differences explain the framing differences demonstrated by breastfeeding activists in the U.S. and Canada.

Framing Differences Across Organizations

In this section, I examine the ways in which framing strategies differ across organizational type (i.e., lay activist, medical, or governmental organizations). Table 3.3 illustrates the different uses of framing arguments across organizations. I begin this section examining similar framing across organizational type. Here I explore how strategic coalitions (introduced in Chapter Two) enhance our understanding of the ways in which multiple organizations in the same movement can be homogeneous in their framing strategies. Then, I examine variation in framing across organizational types and look at how, despite working towards the same goal (increasing breastfeeding rates), different organizations will construct their arguments in a variety of ways. Finally, in this section I examine framing variation across organizational type and across geographical location.

TABLE 3.3: PERCENTAGE OF DOCUMENTS USING PARTICULAR FRAMES BY ORGANIZATION TYPE

Framing Strategy	*Lay Activist (N=105)*	*Medical (N=32)*	*Government (N=57)*	*Total (N=200)*
Baby-saving Frame	56% (59)	67% (21)	67% (38)	59% (118)
Formula Risk Frame	35% (37)	25% (8)	33% (19)	32% (64)
Mother's Health Frame	21% (22)	40% (14)	23% (13)	25% (49)
Social Good Frame	10% (10)	9% (3)	19% (11)	12% (24)
Rights Frame	13% (14)	3% (1)	18% (10)	13% (25)

I. Similar Framing Across Organizational Type

As this table demonstrates, the baby-saving frame is the most common framing strategy across and within each organizational type (used by 59 percent of documents overall, 56 percent of lay activist documents, 67 percent of medical documents and 67 percent of government documents). Therefore, we have government, lay, and medical organizations each more likely to draw on this framing strategy than any other kind of argument. We can see even see similar wording across organizational types. For example, the USBC (a government organization) states that breastfed children:

> have a lower incidence of sudden infant death syndrome (SIDS); are less likely to suffer from infectious illnesses and their symptoms (e.g., diarrhea, ear infections, respiratory tract infections, meningitis; have a lower risk of the two most common inflammatory bowel diseases (Crohn's disease, ulcerative colitis); suffer less often from some forms of cancer (e.g., Hodgkin's disease, childhood leukemia); have a lower risk of juvenile onset diabetes (USBC 2005).

Likewise, the LLL (a lay activist organization), argues that "long-term effects of breastfeeding include reduced risk of celiac disease, diabetes, obesity, some childhood cancers, Crohn's disease, urinary tract infections, atopic disease, and reduced endometriosis" (LLL 2005). Finally, both major pediatric medical associations, the AAP and CPS, recommend exclusive breastfeeding for the first six months of life because, as the AAP (2005) argues, "breastfed children are less likely to have the following: ear infections (otitis media); allergies; vomiting; diarrhea; pneumonia, wheezing, and bronchiolitis; meningitis." The popularity of this framing strategy across organizational type highlights how each organizational type is capable and willing to take advantage of "risky childhood" and medical authority as discursive opportunities.

Furthermore, following the baby-saving frames, formula risk and mother's health frames were the next most likely to be used by any organization (used in 32 percent and 25 percent of documents, respectively). All three of these framing strategies, including the baby-saving frames, focus almost exclusively on medical arguments. Therefore, as discussed earlier, most of the organizations drew on the discursive opportunity of increasing medical authority to provide evidentiary claims and persuasive power to encourage mothers to breastfeed. For example, government organizations cited medical organizations in their breastfeeding recommendations, drawing on medicine as a source of authority. The USBC (2000) writes:

> The United States Breastfeeding Committee's considered opinion is that healthy full-term infants be exclusively breastfed for about six months. This point of view is supported by expert opinions such as those expressed in the American Academy of Pediatrics Policy and the American College of Obstetricians and Gynecologists Educational Bulletin regarding the positive impact of breastfeeding on women's health, infants' health, and the enhanced relationship between mother and infant.

In another example, LLL cites both government and medical associations to give weight to their breastfeeding argument. They write:

> The Surgeon General of the United States has called breast milk the most complete form of nutrition for infants, and according to the American Academy of Pediatrics' statement about breastfeeding, 'From its inception, the American Academy of Pediatrics has been a staunch advocate of breastfeeding as the optimal form of nutrition for infants.' (LLL 2006)

Finally, Health Canada, the CPS and the Dieticians of Canada collaborated in the development of a statement that argues, "breastfeeding is the optimal method of feeding infants" (Health Canada 2005). The extensive use of medical arguments demonstrates both the scale of medical authority as a discursive opportunity as well as another example

of how health social movements cultivate inter-organizational alliances across types of institutions.

Therefore, we see homogeneity across organizations in the common use of these breastfeeding framing strategies. Scholars generally assume such homogeneity across organizations and argue that movement activists must present an air of solidarity in order to be most effective in persuading their audience (Hirsch 1986). In this case, such findings are particularly interesting because we see the alignment of activists with competing interests. Generally, lay activists and government organizations are at odds with one another because lay activists tend to challenge government organizations to provide more or less structural intervention for a particular issue. However, in the breastfeeding movement, government and lay activist groups have developed coalitions as they work for the common goal of increasing breastfeeding rates. In fact, what we see in the breastfeeding movement is the presence of *strategic coalitions*.

Strategic Coalitions

A notable development that emerged in breastfeeding activism, particularly in its transition into a movement, is the coalitions between women's organizations, the medical field, and the government. A similar pattern of differently interested organizations working towards the same cause is examined in Klawiter's (1999) work on the breast cancer movement. In this piece, Klawiter examines the utility in and consequences of either strategically supporting or actively contesting potentially controversial institutions. In this case, the Susan G. Komen Foundation relied upon the support of and endorsement from the medical community in their efforts to encourage early detection of breast cancer

and medical intervention as the keys to a successful battle against the disease (and, in fact, funds biomedical research for the prevention and treatment of breast cancer). In contrast, another breast cancer activist organization, the Women & Cancer Project, actively campaigned against the failure of medical organizations to recognize the diversity of women's breast cancer experiences based on different cultural backgrounds and a general ignorance regarding women's health related issues by the medical community. Therefore, the Susan G. Komen Foundation formed a strategic coalition with medicine in order to give authority to their activism against breast cancer and a reliance on the institution of medicine as a possible solution to their social concern. They did not risk jeopardizing this relationship by questioning the actions and findings of this institution. The Women & Cancer Project, however, did not form a strategic coalition with the medical community but instead was actively challenging medicine to better respond to the lived experiences of women.

As discussed in Chapter Two, breastfeeding activism became organized when feminist and maternalist activists began working together against medical control and intervention. However, medical arguments are the most common arguments used by any kind of contemporary activist organization. Moving the primary focus of breastfeeding activism towards a medical and health issue ignored activists' concern with male domination in the medical field and women's collective bonding experience of motherhood. However, it seems that these women's organizations recognized the strategic utility in collaborating with the medical field. Rather than rejecting all notions of medical benefits to breastfeeding, feminist and maternalist groups have utilized medical arguments, along with their own arguments, in order to make a more persuasive

case to their targets. Furthermore, it is likely that medical organizations have become more responsive to the concerns and complaints of breastfeeding organizations (e.g., the inclusion of mother's health frames in medical literature). Because increasing initiation and duration rates of breastfeeding is the primary goal, these activists seem to have accepted some medical co-optation while also taking advantage of medical authority as a discursive opportunity.

These findings suggest a change since Blum (1999) identified two models for breastfeeding activism—medical and maternal. She discusses a type of maternalism that tends to reject medical arguments and issues associated with breastfeeding, focusing instead (like the maternalists of late) on the embodied experience of breastfeeding. Her prime example of this model of breastfeeding is LLL. However, since her data collection in 1990, we now see that even devoutly maternalist organizations, such as LLL, draw on medical arguments. They write:

> The American Academy of Pediatrics states that exclusive breastfeeding is the ideal nutrition for the first 6 months and that breastfeeding with the addition of appropriate complementary foods should continue for at least twelve months and thereafter for as long as mutually desired. (LLL 2002)

The LLL website also offers links to multiple medical association websites, demonstrating an alliance regarding the importance of breastfeeding. Furthermore, this alliance is mutual. We not only see activist groups, such as LLL, citing medical organizations as a source of authority. Government and medical professional organizations also cite LLL as a source of valuable emotional and practical support when faced with breastfeeding challenges. For example, the US-DHS has joined forces with LLL to provide a hotline for mothers with breastfeeding questions (i.e., nursing positions, pumping storage) and immediate encouragement and support when faced with nursing

struggles. By drawing on the expertise of LLL, the US-DHS recognizes the advances that LLL has made regarding their mother-to-mother breastfeeding support and the importance of that support in increasing breastfeeding rates.

Although these coalitions are strategic, they are also fragile since many activist groups do campaign for an increase in structural support for breastfeeding mothers by the government. For example, in a newsletter LLL activists comment on the U.S. government's blueprint to increase breastfeeding. They write:

> [T]he plan does not make specific recommendations about legislation that would support a mother's plans to breastfeed. Most employers do not perceive breastfeeding to be an issue warranting their attention. In the United States, in comparison to many other industrialized nations, there are no federal statutes with specific provisions and protections for nursing mothers. (LLL 2001)

It is these strategic coalitions and simultaneous alliances and contestations that illustrate the unique circumstances of health social movements.

II. Different Framing Strategies Across Organizational Type

In this section, I explore the ways in which organizational types differ in their strategies of persuasive framing.

Lay Activists

As an organizational type, lay activists are generally more radical in their framing activities than other institutional organizations, such as government and professional groups. Although all groups are capable of losing their supporters and legitimacy by utilizing extremely radical arguments and tactics, lay activist groups have more freedom to push the boundaries of what arguments are considered "too extreme." With regard to

breastfeeding activism, lay activists used the more radical formula risk frames in 35 percent of their documents and rights frames in 13 percent of their sampled documents.

Formula risk frames are one of the more radical strategies as activists work to construct formula feeding as a "dangerous" behavior. These arguments try to link many unexplainable illnesses or poor health outcomes to being directly *caused by* feeding a child formula rather than breast milk. These arguments truly rely on a culture of intensive motherhood in order to "guilt" mothers into feeling that formula poses a threat to their children's health and by feeding their child formula, they may be putting her/him in danger. For example, INFACT (2004e) has a pamphlet outlining the "Risks of Formula Feeding" to fully inform parents of the "health hazards" of infant formula. This list of dangers includes threats often listed in the baby-saving arguments (e.g., increased risk of asthma, allergy, delayed cognitive development, respiratory disease, cancer, mortality); however, the argument is presented such that feeding a child formula *causes* these negative health outcomes. Similarly, LLL (2005) argues that activists need to focus more on the "health risks of formula feeding, including an increased risk of diabetes and increased rates of childhood cancer." Furthermore, drawing on the culture of intensive motherhood and the discursive opportunity of risky childhood, this LLL pamphlet reads, "Why breastfeed? To keep your child from getting sick and dying…This is your baby. You want less than the best for your baby? Your choice" (LLL 2005b). Therefore, lay activist groups were more likely than medical or government organizations to draw on the formula risk framing strategy, pushing the boundaries of making women feel guilty for formula feeding their child.

Lay activist organizations were also more likely than any other group to draw on a rights framing strategy. In fact, medical and government organizations rarely used this strategy at all. In a handout, INFACT (2004a) activists write, "Breastfeeding is a fundamental Human Right. If your rights – or the rights of any breastfeeding mother – are violated, contact your local branch of the Canadian Human Rights Commission and file a complaint." Furthermore, in an article by LLL, activists write about their concerns with the legal protection of breastfeeding mothers. They outline the laws protecting the rights of mothers nursing in public and advise readers to write to the legislators to encourage more protections of public breastfeeding (LLL 2005a). These arguments that focus on women's right to breastfeed challenge opposition to breastfeeding and implicitly demand legal protection for women who choose to breastfeed (especially in public).

Medical Organizations

It is not surprising that most of the arguments used by medical organizations are those utilizing medically-based claims. Of the medical organizations' documents, 67 percent utilized a baby-saving strategy, 40 percent utilized a mother's health strategy, and 25 percent utilized a formula risk strategy. For example, a variety of professional medical associations have issued statements supporting the medical recommendation to breastfeed, including: the American College of Obstetricians and Gynecologists (ACOG) who write, "breastfeeding is the preferred method of feeding for newborns and infants" (ACOG 2003); the CPA (2001) who write, "breastmilk is the biologically ideal food for infants and breastfeeding is an important immediate and long-term preventive health care measure for both infant and mother"; and the American Dietetic Association (ADA) who

write, "exclusive breastfeeding provides optimal nutrition and health protection for the first 6 months of life, and breastfeeding with complementary foods for at least 12 months is the ideal feeding pattern for infants" (ADA 2005). Most of these statements simply endorse the statements of the AAP and CPS and cite the findings of medical professional research to demonstrate the importance of breastfeeding.

Medical activists addressed the health benefits of breastfeeding thoroughly in their policy statements and supported medical claims regarding the benefits of breastfeeding (and the risks of formula feeding). Therefore, they drew almost exclusively on medical framing strategies using baby-saving, mother's health, and formula risk frames in most of their documents. In fact, medical organizations were the organizational type the least likely to use a rights framing strategy (in three percent of the sampled documents) and social good framing (nine percent of the time).

Government Organizations

Government organizations drew on baby-saving and formula risk framing strategies more than any other. They used baby-saving framing frames in 67 percent of their documents and formula risk framing in 33 percent of their documents. Examples of the baby-saving frame include statements in which the USBC argues that "Research has shown that breastfeeding supports optimal growth and development for infants, and offers lifelong health advantages" (USBC 2002b). Similarly, Health Canada "promotes breastfeeding as the best method of feeding infants as it provides optimal nutritional, immunological and emotional benefits for the growth and development of infants" (Health Canada 2005). However, government organizations were also the group most

likely to use formula risk framing. Examples from the same two organizations include the following statements.

> From the USBC: Not breastfeeding also carries intangible costs – those not associated with specific dollar amounts in research findings. Such costs include: Illness and death from bacteria associated with feeding powdered infant formulas, which is not sterile; 3- to 11-point IQ deficit in formula-fed babies; Less educational achievement noted with both formula-fed children and through adulthood (USBC 2002c).
>
> From Health Canada: Newborn infants breastfed for 13 weeks or more had significantly fewer gastrointestinal and respiratory illnesses during the first year of life when compared to formula-fed infants. In comparison to formula-fed infants, infants exclusively breastfed for a minimum of 16 weeks had fewer episodes of single and recurrent otitis media during the first year of life (Toronto Public Health 2009).

Government activists drew on a mother's health framing strategy in 23 percent of their documents. For example, the US-DHS women's health website (womenshealth.gov), tells women "Breastfeeding—Best for Baby, Best for Mom" because:

> Breastfeeding saves time and money. You do not have to purchase, measure, and mix formula, and there are no bottles to warm in the middle of the night. Breastfeeding also helps a mother bond with her baby. Physical contact is important to newborns and can help them feel more secure, warm and comforted. Nursing uses up extra calories, making it easier to lose the pounds gained from pregnancy. It also helps the uterus to get back to its original size more quickly and lessens any bleeding a woman may have after giving birth. Breastfeeding may also lower the risk of breast and ovarian cancers. (US-DHS 2005)

Similarly, the Canadian Public Health organization argues that breastfeeding is best for mothers because it:

> promotes closeness and bonding of mother and baby, helps the uterus to return to its normal size after birth, helps to control bleeding after birth, helps to protect against breast cancer and ovarian cancer, helps to keep bones strong, and helps with weight loss after birth. (Toronto Public Health 2009)

Therefore, government organizations not only focused on encouraging mothers to breastfeed for their children's health but were also likely to point out the ways in which mothers benefit from breastfeeding as well.

Interestingly, government organizations were the group most likely to draw on rights and social good framing strategies. They used the rights framing strategy in 18 percent of their documents and the social good strategy in 19 percent of their documents. The Canadian Public Health organization uses the rights framing strategy when they argue that the Canadian "Board of Health recognizes that breastfeeding is the optimal method of feeding infants and that mothers have the right to breastfeed their babies anytime, anywhere" (Toronto Public Health 2007). The use of social good framing can be seen when the USBC lists several economic and environmental rewards for society that breastfeeding provides. These include:

> Breastfeeding reduces the need for costly health services that must be paid for by insurers, government agencies, or families. Breastfeeding reduces the number of sick days that families must use to care for sick children…[and] Electricity or fuel are consumed in the preparation of infant formula. (USBC 2002a)

Also, the Canadian Public Health group argues that breastfeeding is "best for families" because it: "saves money; saves time – breastmilk is always fresh and ready; and does not produce any garbage" (Toronto Public Health 2009).

Clearly, government organizations were more comfortable drawing on medically based arguments, as that accounted for most of the framing strategies used in their documents. However, they were the group most likely to draw on the two community based framing strategies. We may gain insight into these findings by further breaking down this analysis by both country and organizational type.

III. Framing Variation Across Organization and Country

In this section, I outline the differences in framing strategies across organizational type and within each country. Table 3.4 shows the distribution of arguments present in each kind of organization's documents.

TABLE 3.4: PERCENTAGE OF DOCUMENTS USING PARTICULAR FRAMES BY COUNTRY AND ORGANIZATION TYPE

	U.S. Orgs			*Canadian Orgs*		
Framing Strategy	*Lay Activist (N=56)*	*Medical (N=14)*	*Govt. (N=30)*	*Lay Activist (N=49)*	*Medical (N=18)*	*Govt (N=27)*
Baby-saving Frame	57% (32)	93% (13)	77% (23)	55% (27)	44% (8)	57% (15)
Mother's Health Frame	23% (13)	43% (6)	23% (7)	18% (9)	44% (8)	22% (6)
Formula Risk Frame	21% (12)	21% (3)	40% (12)	41% (20)	27% (5)	26% (7)
Rights Frame	11% (6)	0% (0)	3% (1)	16% (8)	6% (1)	33% (9)
Social Good Frame	7% (4)	14% (2)	13% (4)	22% (11)	6% (1)	26% (7)

Lay Activists

Here we see that lay activists from each country were similarly likely to use a baby-saving strategy (57 percent in the U.S. and 55 percent in Canada) or mother's health frame (23 percent in the U.S. and 18 percent in Canada) in their documents. However, Canadian lay activists used a formula risk framing strategy in 41 percent of their documents while it was present in only 21 percent of U.S. lay activists' documents. It is possible that because Canadian women had the structural support needed to encourage

breastfeeding, these activists felt that mothers who were resistant to choosing to breastfeed could only be persuaded with a more radical approach. These Canadian lay activists made sure that their audience connected formula feeding with dangerous health outcomes to pressure them to breastfeed rather than formula feed. For example, a Dr. Jack Newman handout argues that it is a myth that "modern formulas are almost the same as breastmilk." He goes on to say that "Modern formulas are only superficially similar to breastmilk…Formulas contain no antibodies, no living cells, no enzymes, no hormones…Formulas are made to suit every baby, and thus *no* baby" (Newman 2003a).

Along the same lines, Canadian lay activists used the social good framing in 15 percent more of their documents than U.S. lay activists. It is likely that this strategy also stems from needing to use a more radical approach in order to convince mothers to breastfeed; therefore, they worked to link breastfeeding as an expected contribution to their community. See, for example, the following newsletter from INFACT (2004f). They write:

> Social supports for mothers and parents not only facilitate the critical role of nurturing but also validate the considerable societal contribution that women make when breastfeeding their children. Breastfeeding spares the government significant health and other social and educational costs because breastfed children are healthier throughout their lives. Although it is difficult to put a dollar amount on the savings generated by breastfeeding mothers, for a country like Canada it is likely in the billions of dollars annually.

Canadian lay activists may have a different strategy than U.S. lay activists because so many more Canadian women are already breastfeeding. Therefore, they had to resort to a more radical strategy in order to persuade the "stragglers."

Medical Activists

U.S. and Canadian medical organizations were actually quite similar in their framing strategies. Although the U.S. activists drew on the baby-saving frame in nearly all of their documents (93 percent), Canadian activists still used baby-saving and mother's health frames most of the time (88 percent of their documents). Neither of these organizations was very likely to use either of the community framing strategies. In fact, the U.S. medical activists never used a rights strategy and rarely used a social good strategy while Canadian activists only drew on these frames in 12 percent (combined) of their documents.

Government Activists

The U.S. and Canadian governments were similar in their framing strategies. A majority of their documents used either the baby-saving or mother's health framing strategies in order to persuade their constituents to breastfeed. However, one of the more striking differences between the strategies in these two countries is that U.S. government activists only used a rights framing strategy in three percent of their documents while 33 percent of the Canadian government documents used this frame. As previously discussed, the U.S. government has been more resistant to providing the structural supports encouraging mother's to breastfeed, making it unsurprising that they are not likely to draw on a rights framing strategy. The core of this argument is the perspective that mothers should be publicly supported in their efforts to breastfeed and that this should be enforced legally, if necessary. Unlike some of the legal and social support systems established for breastfeeding mothers in Canada, women in the U.S. are often left

to their own devices in order to make the best of their infant feeding decision. Therefore, it makes sense that U.S. government activists would not utilize arguments that could be worked against them in order to demand more structural support.

Conclusion

This chapter has outlined the ways in which breastfeeding activism has functioned as a social movement. Of particular interest were the framing strategies used by activists in this movement. After summarizing the kinds of frames used by breastfeeding activists, I examined how these arguments "do" embodiment and boundary work, essential characteristics of health social movements. This analysis expands our understanding of health social movements by giving researchers a demonstration of the unique qualities of this kind of activism. For example, we see the "pseudo-embodiment" that I predicted in Chapter Two whereby mothers take on the embodiment of their children's health. They are not only held responsible for their children's health outcomes, but, with regard to breastfeeding, it is literally the giving of their body that can potentially provide protection from some unwanted illnesses. Nonetheless, these activists use threats against the biological body of both child and mother to persuade women to breastfeed their children. Therefore, this research expands the definition of embodiment with regard to embodied health movements.

Furthermore, breastfeeding activism provides us with an excellent opportunity to examine the boundary work present in this kind of movement. I showed how breastfeeding activists effectively blurred the boundaries between experts and lay people, challenged what is meant by good or bad science, and allowed activists to cross

traditional movement boundaries and draw on the activism of only tangentially related movements. These findings enhance our understanding of embodied health movements and the boundary work that they do. In particular, the breastfeeding movement highlights the unique ways in which embodied health movements can simultaneously contest and ally with scientific authorities. In this movement, groups like LLL work with medical associations to strengthen their own legitimacy while also challenging the medical focus of those institutions.

In the next sections, rather than assuming homogeneity in framing strategies, I examined framing variation activists in the breastfeeding movement. I began by comparing differences in framing strategies used by activists in the United States to those in Canada. In this analysis we see the effect of different cultural contexts on the frames most likely to be used in breastfeeding activism. Activists in both countries were able to draw on growing medical authority and the cultural construction of "risky childhood" as discursive opportunities for framing. However, activists in each country differed in their use of rights framing in each country. I argue that it is the neoliberal cultural in the United States that prevents activists from using communal framing strategies. These community focused arguments are likely to create a sense of social responsibility with regard to breastfeeding such that mothers are responsible to their community to breastfeed for the social benefits while her community is responsible for providing structural supports for mothers to be able to successfully breastfeed. These findings enhance our understanding of the cultural differences between the United States and Canada as well as the consequences of these differences with regard to health care activism.

In the next section, I examined how the different organizational types compared in their use of particular framing strategies. In addition to expanding our understanding of frame variation, I was able to highlight the unique ways in which embodied health movements utilize strategic coalitions to advance their cause. I demonstrated an expansion of the field of breastfeeding activism, moving from a dichotomous medical versus maternal model to a much more strategic and practical approach to activism. Rather than competing with each other while working towards similar goals, these groups have compromised some of their original standards in order to make more compelling, unified arguments. Therefore, maternalist organizations are now likely to draw on the medical authority to make breastfeeding claims, while the medical community is now likely to recognize the importance of groups, like LLL, that provide mother-to-mother support for breastfeeding. These findings improve researchers' knowledge regarding the strategic capacity of social movement activists and their ability to join together while remaining contentious on some issues.

In closing, some frames are particularly prevalent across organizations and within both countries, indicating consensus among movement actors on certain points. However, the variation that is quite evident across activists in this movement demonstrates how important it is for scholars to refrain from assuming homogeneity across all movement actors. Instead, researchers must be sensitive to ways in which different organizational types and cultural contexts may affect the likelihood of using particular framing strategies.

Now that I have examined the framing strategies present in the breastfeeding movement, I move to the analysis of responses from intended targets of this activism. In

this case, I examine how mothers construct and understand infant feeding and how these interpretations intersect with, challenge, or reaffirm the discourses established by these dominant institutions.

Chapter IV

MOTHERS' INTERPRETATIONS OF BREASTFEEDING

Introduction

In this chapter, I examine mothers' own interpretations of infant feeding and the ways in which their constructions intersect with, contests, or reaffirms the dominant discourse established by breastfeeding movement activists. Thus far, I have examined the frames, or arguments, that breastfeeding activists used in an effort to persuade mothers to breastfeed, rather than formula feed, their children. Having established the "dominant discourse" of breastfeeding, I now present mothers' own interpretations of breastfeeding. This analysis enhances our understanding of the lived experiences of mothers, the main addressees of breastfeeding movement activism, and whether or not mothers tend to draw on the frames and arguments used by activists in their own construction of infant feeding. As I will discuss at the end of the chapter, such findings have important implications for both feminist research on motherhood and literature on the effectiveness of framing strategies.

In this chapter, I connect mothers' receptivity to dominant breastfeeding discourses via their understanding of the dominant mothering ideology. Although I made repeated efforts asking women about where they learned of particular breastfeeding messages, these women were unable to specify where they had encountered such discourses. I asked questions and probes that included whether or not they had encountered the phrase "breast is best" and if so, where. I asked them whether they knew

whether or not the government had particular recommendations regarding breastfeeding and if so, what those recommendations were and where they learned of them. Also, I asked them if they were familiar with the particular infant feeding stance of groups such as LLL and major medical associations. Rarely were women able to pinpoint the positions of each of these organizations. The few who did know the positions of these organizations could not articulate where they had encountered those messages. Although all of these women had certainly encountered the idea that breastfeeding is the preferred and recommended method of infant feeding, they could not specify sources of such information. Such an inability to articulate the sources of these messages demonstrates their hegemony. Alternative messages—for instance, that formula feeding is a better or equivalent infant feeding method than breastfeeding—are effectively silenced and generally absent in the broader culture. For example, even in formula commercials the ads state that breastfeeding is always best for your child, but when you cannot breastfeed, use "this" formula. These absences led me to connect the dominant breastfeeding messages with the dominant discourses of ideal motherhood.

Like the breastfeeding messages I discussed in Chapter Two, messages about the expectations of ideal motherhood are also ubiquitous. One piece of the ideal mothering ideology is the expectation to breastfeed. In this chapter, I address patterns in women's commitment to dominant mothering ideologies and the ways in which that commitment intersects with women's beliefs about breastfeeding. First, I examine differences in women's commitment to the dominant ideology of motherhood and the ways in which they define "good" motherhood. Next, I look at how women varied in their commitment to breastfeeding and the arguments they drew on to justify their position. Then, I

investigate how women's commitment to a dominant mothering ideology affected their commitment to breastfeeding. Finally, I conclude with a discussion of the complexity of women's ideological commitments by making a variety of comparisons with regard to women's commitment to breastfeeding, including differences between women from the U.S. and Canada, how women's breastfeeding commitment compares with the length of time they breastfed, and how women's breastfeeding commitment intersected with their resistance to medicalized childbirth.

The data from this chapter are drawn from interviews with 44 mothers, 22 from the Nashville and 22 from Toronto. (Details of data collection are addressed in Chapter Two.) These interviews explored how mothers, in their own words, constructed infant feeding. I coded these data for patterns in women's understanding of breastfeeding and whether or not they drew on the language of breastfeeding activists. I now articulate the patterns that unfolded in this examination.

Dominant Mothering Ideology

As discussed in Chapter Two, North American mothers today are subject to a very rigid discourse regarding constitutes "good" motherhood, such that the dominant discourse has constructed an ideal mother. Although all of the mothers in this project experienced pressure from this dominant mothering ideology, women varied in their levels of acceptance and rejection of this mothering standard. This ideology says that mothers are responsible for the primary care giving of their children and that they should happily provide an unlimited amount of care because their children should come first (Hays 1996; Thurer 1995; Warner 2005). Although discussed in further detail in Chapter

Two, I now provide a definition of what ideologies are in general and then briefly overview the dominant ideology of intensive motherhood.

I. Ideologies

Ideologies are cultural "lenses that filter and, to varying degrees, distort our experience and understanding" of the world (Glenn 1994:9). Ideologies are group, not individual, products created from shared beliefs about how the world should work and how people should live within it. Furthermore, some ideologies are given a dominant position and become the standard by which beliefs and behaviors are measured. For example, the dominant mothering ideology suggests that women have a biological responsibility to motherhood such that "all women need to be mothers, that all mothers need their children, and that all children need their mothers" (Glenn 1994:9). A component of the contemporary dominant mothering ideology is the expectation of intensive mothering.

As discussed in Chapter Two, intensive mothering is a belief system that demands that mothers provide unlimited amounts of care, attention and affection to their children (Hays 1996). This dominant discourse of motherhood has been described as one that sees mothers as "selfless" and "sacrificial" (Hays 1996; Thurer 1995; Warner 2005). That is, mothers are expected to focus primarily, if not exclusively, on their children's needs rather than on their own desires and needs. Furthermore, mothers are increasingly being held responsible not only for the health and well being of their children, but also for their cognitive and intellectual development, and their overall short-term and long-term success in life (e.g., Wall 2001). Breastfeeding fits within this dominant intensive

mothering ideology as it is constructed as the ultimate infant feeding method—the healthiest way to feed a child and one of the best ways for an infant and mother to bond. Breastfeeding very often requires a considerable amount of time from the mother, as she is the only one who can provide the child this sustenance. A breastfeeding (and/or pumping) mother must also have dedication to persevere through the physical struggles that she may encounter. We see activists in the breastfeeding movement draw on this ideology in the construction of their persuasive arguments, encouraging mothers to fear for their children's future health and possibly even feel responsible for failing to best protect their children if they do not breastfeed.

The women in this project varied in their commitment to the dominant mothering ideology as well as their justification for that kind of commitment. Table 4.1 demonstrates this variation by presenting percentages of commitment level and justifications by the women in this sample. Because the women were able to, and often did, use more than one argument, the argument percentages do not add up to 100. Although, as Hays (1996:131) argues, "all mothers ultimately share a recognition of the ideology of intensive mothering," some women were strict in their allegiance to intensive motherhood while others were much more flexible. The strictly committed women believed that motherhood could not be understood in any way other than according to the dominant standards. In contrast, other mothers were resistant to the idea that one conception of motherhood should be applied to all women. These women were much more flexible in their ideological commitment to intensive mothering. Differences in commitment to the dominant standards of motherhood are examined below.

TABLE 4.1: PERCENTAGE OF MOTHERS' IDEOLOGICAL COMMITMENT TO INTENSIVE MOTHERING IDEOLOGY	
Commitment Level and Arguments	*Percent of Mothers (N=44)*
Strictly Committed	**55% (24)**
Selflessness	79% (19)
Being Present	41% (10)
Flexibly Committed	**45% (20)**
Flexibility	65% (13)
Patience	45% (9)

II. Mothers' Acceptance or Rejection of Intensive Motherhood

The mothers in this project varied in the ways they defined "good" motherhood and varied in their commitment to the ideals of intensive motherhood. Some women "bought into" the dominant ideology of motherhood and described good mothers as those who were selfless and always "present" with their children. In contrast, some mothers fell on the other end of the spectrum. Such women articulated the challenges of motherhood and described their efforts to live up to the dominant expectations as difficult. They defined "good" mothers as those with patience and tended to reject the concept of one standard for all mothers.

Strictly Intensive Mothering

The women committed to intensive motherhood as ideal had a very particular conceptualization of what "good" motherhood meant. The mothers with a strict

commitment described characteristics of good mothers as those who are "selfless" and "present." These characteristics are also a part of the dominant model of motherhood.

Selflessness

Many (79 percent) of the women with a strict commitment to the intensive mothering ideology said that a characteristic of a "good" mother was selflessness. These women, likely pulling from the dominant discourse of ideal mothering, argued that mothers must have concern for their children first, before themselves or anything else. For example, when describing what a "good" mother is to her, Rachel, 37, from Canada, says:

> You have to give up all selfishness when you're a mother. You have to realize that when you have children, you have made a sacrifice and that your child will always come first. You chose the child, but the child didn't choose to be born and it's your job to take care of that child above everything else. It has to be your priority.

Similarly, Ella, 38, from Canada, says:

> I think one of the first things I learned is that you have to be completely selfless. You know, your child, their needs, their wants come first. And, I think if, if someone tries to resist that, and tries to fight against the feeling, that that's probably a bad mother in my view…I'm not saying that mothers have to be like a martyr, but I think you have to realize your baby comes first and you do give up a lot of stuff. And one day, you know, you'll have your life back.

These women are explicit in their construction of a good mother as someone who puts herself on the backburner, first addressing any needs her children might have. Ella even argues that mothers who do not align with this ideology of selflessness should be considered "bad mothers."

In fact, Faith, 30, from the U.S., goes so far as to say that a mother not only loses her individual identity but also loses her body. She says, "You're not living for yourself anymore, for a while especially. I think your body is not your own, and you just have to be okay with that." Furthermore, these women identified selflessness as a type of love that mothers can demonstrate to their children. Leah, 28, from the U.S., for example, says that a "good" mother has, "Well, first love. Sacrifice. Selflessness. Lots of love, because from love comes everything else." These women illustrate how mothers who are strongly committed to the dominant ideology of motherhood define selflessness and an intensive style of mothering as a form of love for one's children and a way of being a "good" mother. These women draw on the dominant discourses of intensive motherhood to define their own lived experiences and their expectations for women's mothering practices.

Being Present

Another way in which 41 percent of the mothers who were strictly committed to intensive mothering described "good" motherhood was through "being present." These mothers explain this characteristic as a way of being attentive to a child's needs and not taking for granted any time that she spends with her child. Hailey, 39, from Canada, says that good mothers will always try to "be very present with your kids. You know what I mean? If they need you, they need you. Always be there for them." Diana, 36, from Canada, agrees when she says what is important is "Consistency, being there, being present. And I don't mean just physically, I mean mentally." These women expect mothers to devote not just physical but mental and emotional energy to children.

According to this ideology, mothers are expected to give all that they can to their children and make the most of every possible moment to appreciate the time they have with their children.

This perspective—that "good" motherhood requires an unending amount of attention, affection, and selflessness—is a very demanding expectation for mothers. These women strictly believed in the standards of intensive mothering and expected those behaviors (and sacrifices) both from themselves and other mothers. Characteristic differences in women and their commitment to intensive mothering will be explored below.

Flexible Mothering Ideology

Mothers with a flexible commitment to the dominant mothering ideology tended to describe "good" motherhood differently than those with a strict commitment to intensive mothering. Generally, they did not mention selflessness or the need to "be present" in order to care effectively for their child. In contrast to the previous group of women, these mothers described the need to be flexible with their children, and that there was more than one way to "correctly" mother a child. Secondly, they discussed the challenges of motherhood and emphasized the importance of patience in order to resist frustration. These women were flexible in their understanding of "good" motherhood, arguing that standard rules can rarely apply to all people in all circumstances.

Flexibility

As mentioned, the women with a flexible commitment to the dominant standards of motherhood tended to agree that there was not one cut-and-dried way to parent. Instead, 65 percent of these women argued that mothers needed to figure out what sort of parenting style worked best for them and their children. One component of this flexibility is ensuring that mothers are not taking too seriously every bit of advice that they receive. Jennifer, 28, from Canada, discussed how "good" mothers should always stay on top of new information available about childrearing, but should also discriminate which advice they should follow. She says:

> I think it's important to read and stay on top of what's going on out there. You know, safety issues and feeding issues. You want to make sure that you're well informed. But, you're not necessarily taking in all of the advice, especially that unsolicited advice from any Tom, Dick, and Harry walking down the street. You know, you do have to pay attention to where you're getting your advice from and make decisions on what advice will work best for you.

This notion of needing to be discriminating in the mothering advice that she takes suggests that there are some kinds of advice that are unproductive if taken too seriously. This description also highlights the flexibility with which this group of women is able to approach motherhood, by taking in all kinds of advice and then sorting through to figure out which bits work best. Another example of this kind of flexibility at work is demonstrated when Margo, 35, from the U.S., says that a mother is "good" when she is:

> listening to your children and not listening to every single thing everybody else says…Yeah, I realize that, you know, every child is different, every mother is different, every situation is different. I used to be like, 'I'll never use a pacifier,' and—my goodness, if I could just get my second child to take a pacifier I would be in heaven, you know?

These women are critical of the idea that there are such rigid rules for parenting. In contrast, they believe that different parents, children, and situations call for flexibility, and spontaneity in figuring out what the most appropriate response should be. Similarly, Jada, 41, from Canada, says that to be a good mother you need to "be sensitive to the personality of your child. There's no such one size fits all." Also, Audrey, 41, from Canada, says that along her journey through motherhood, she's realized that:

> What I thought the reality of being a parent was is very different than what it actually is. Because, real life happens and lots of stress happen, so, you know. I've just learned that, maybe before I thought to be a good parent you need to be home with your kid, you need to be the primary one that took care of them…I've just learned that not everybody is cut out to be a stay-at-home mom. And you can be a great mom working outside of the home.

These women have come to realize that a key component of "good" motherhood is some flexibility; that neither themselves nor their children may have a textbook response to a given situation.

Patience

Another pattern that emerged among these women's descriptions of "good" motherhood was the importance of patience. Forty-five percent of these women often articulated the challenges of motherhood and that being a mother is much more difficult than they originally expected (as can be seen in some of the above quotations). In response to these challenges, they described the importance of patience for "good" mothers. For example, Sydney, 26, from the U.S., talks about all the challenges she experienced with her infant, such as trying to establish a breastfeeding latch and get her daughter to sleep. She says the key to good motherhood is "Patience. Yes, yes, I mean

patience, which I don't always have. I think, really, patience. Sleep would also probably help a good mother. Patience and understanding." She goes on to say that being a "good" mother has been really hard for her, especially in her decision about whether or not to go back to work. But, Sydney says she has learned that:

> A happy mother is a good mother, you know…I was going insane being with this child, so I couldn't be a good mother. But, if I go away for a few hours and then I come back, I can enjoy her. Then, that makes a better mother than me staying here all the time wishing she would just stop crying.

Here, we see Sydney rejecting the dominant ideology of motherhood that expects women to put their children before any of their own needs and that describes mothering as an easy and "natural" experience. Instead, Sydney is faced with a crying infant who has trouble feeding and sleeping and she longs for some sense of her own independence. Given these experiences, she describes "good" mothers as those with patience.

Although Sydney's call for patience stemmed directly from the challenges she experienced, other mothers did not mention having more challenges than the strictly committed mothers, but maintained the importance of patience in succeeding at motherhood. For example, when asked how she describes a "good" mother, Emily, 28, from the U.S., says, "Patience, which is a very hard one to keep sometimes." Similarly, Jennifer, 28, from Canada, comments, "Patience. Lots and lots of patience" and Madison, 36, from the U.S., says, "Definitely patience."

Therefore, when these women do not "buy into" the dominant discourses of motherhood, they are more likely to vocalize the challenges that many mothers face and the hardship of being a new mother. As Autumn, 23, from the U.S. says, the most important characteristic for being a good mother is a:

> Sense of humor. You have to be really committed to your children because, it's…I'm trying to find the words. I feel like even the most committed of people can become very burnt out on it sometimes, so you need a sense of humor to lighten it up.

Furthermore, these women are more likely to describe patience and understanding as the key to being a "good" mother, in order to better handle those challenges.

Of the women in this project, 45 percent women were flexible in their commitment to the dominant mothering standards. These women were critical of contemporary discourses of intensive mothering that define motherhood with very high expectations and very little room for error. They argued that motherhood was not simply a beautiful and joyful experience that should be appreciated, but that it was also hard and they resisted the idea that people should judge women for failing to meet these very high standards. Molly, 36, from the U.S., describes this perspective when she says:

> I probably thought it was a lot easier [before I had kids]…And then, after you have one you're like, uh-huh, you don't have that level of control…You know, they don't sleep well or whatever and you have all these different challenges and things, and just unexpected things. I guess you think that, 'Oh, I read the book. Yeah, I can do this.' But, you know, all babies are different. So, I think, I really realized that there's really no one way to do it, you know. That's probably the bottom line. There's really no one way to parent because every kid is different and every parent is different.

Conclusion

The women in this project varied in their commitment to the dominant mothering ideology. Some of the women were strongly committed to the ideals of intensive mothering and had very high expectations for themselves and other mothers regarding the standards of mothering. In contrast, other mothers were more flexible in their

understanding of "good" motherhood. They were able to interpret motherhood in a variety of ways and were resistant to what they saw as the judgmental standards that categorized them as "good" or "bad" mothers in a very narrow way. In the next section, I examine patterns across the differences in women's intensive mothering commitment.

III. Differences in Commitment to Intensive Mothering

I compared characteristics of women either strongly or flexibly committed to intensive mothering ideology and found two patterns: differences in social class and whether the women were from the U.S. or Canada[9]. The first pattern was social class differences among women's commitment to intensive mothering. See Table 4.2 for a distribution of women's intensive mothering commitment by their social class. Working class women were more likely to be strictly committed (67 percent) to intensive mothering than flexibly committed (33 percent). Middle class women were more evenly distributed between being strictly or flexibly committed with 57 percent of the sample having a strict commitment and 43 percent having a flexible commitment. However, 62 percent compared with 38 percent of the upper class women were more likely to be flexibly committed rather than strictly committed to intensive motherhood. This pattern suggests that social class and commitment to intensive mothering are inversely related.

[9] Women did not differ in the strength of their commitment by age, number of children, and race.

TABLE 4.2: PERCENTAGE OF MOTHERS' INTENSIVE MOTHERING COMMITMENT BY SOCIAL CLASS				
	WORKING (N=6)	*MIDDLE (N=30)*	*UPPER (N=8)*	*TOTAL (N=44)*
STRICT	67% (4)	57% (17)	38% (3)	55% (24)
FLEXIBLE	33% (2)	43% (13)	62% (5)	45% (20)

Hays (1996) argues that the ideology of intensive mothering is middle-class in origin, yet shapes the experience of mothers regardless of class or racial/ethnic background as it is transmitted through cultural products (e.g., books, radio, TV). In this case, middle class women were actually split between being strictly and flexibly committed to intensive motherhood. Rather, it is working class women who were the most likely to be strictly committed to intensive mothering. Although some researchers have questioned Hays' (1996) theory regarding the trickle-down effects of intensive mothering ideology on working class women (Collins 1994; Glenn 1994; Mink 1998; Segura 1994), the women in this sample suggest that working class women were even more likely than middle class women to have a strict commitment to intensive mothering. It is likely that for the women in this sample, Hays' (1996) line of reasoning applies. She makes the case that working class women may "fail" at some parenting standards, simply because of they cannot offer the social capital rewards that mothers with more resources can provide. However, they can still be selfless in their mothering and make sure that their children are the center of their worlds. We can see this kind of reasoning when Leah, 24, from the U.S., says, "I may not be able to give my kids lots of *things*, but I can give them lots of love and show them how to be a good person."

Researchers have thus far failed to question the ways in which upper class women respond to an intensive mothering ideology. Yet, in this case, we see that more upper class women were flexible in their commitment to intensive mothering. Therefore, it was upper class women who were more likely to make arguments that being a mother required some flexibility. For example, Lily, 36, from the U.S., says that being a good mother "requires patience and lots of balancing." She goes on to say that her opinion of "good" motherhood has "changed and evolved" since she's become a mother as she's learned to simply "go with the flow." Similarly, Linda, 37, from the U.S. says that after feeling a lot of guilt for a very difficult pregnancy and delivery, she initially felt like a "bad" mother. However, during the four months after her daughter was born, she came to realize that:

> [My daughter] is going to be fine and that I'm a good mother. I'm alright. I may not be the best mother in the universe, but I'm plenty fine, you know? I haven't dropped her on her head. I give her food. She's fine. I'm fine.

Here we see Linda forcing herself to resist feeling like a "bad" mother for not living up to the dominant standards of ideal motherhood. Rather than allow herself to succumb to the guilt she was feeling, she reconsidered the situation and recognized that despite feeling challenged to meet the very high standards of intensive mothering, she was still a good mother. It is possible that the upper class women were able to meet other standards of "success" (e.g., education, marriage, status, financial stability), thus allowing them some flexibility in their self-worth despite failure or achievement of intensive mothering.

Another difference that emerged between these mothers was that more U.S. mothers were flexibly committed and more Canadian mothers were strictly committed to the ideals of intensive mothering (see Table 4.3 for a distribution of women's

commitments by country). In her work on mothering discourses in Canada, Diana Gustafson (2005) points out that the intensive mothering standards that exist in the United States also apply to mothers in Canada. In fact, Canada's strong tradition of social welfare may make it structurally easier for women to live up to these expectations (i.e., given mandatory maternity leave policies for employers and mothers' ready access to prenatal care). However, these supports may serve as a double-edged sword. Although they do help mothers in their care work efforts, they may make expectations for success higher. Women in the U.S. do not have the structural support necessary for making intensive mothering a more easily achieved option. Therefore, we can interpret U.S. women's more flexible commitment to intensive mothering as both a form of resistance to these high ideals of intensive mothering and a pragmatic response to a structurally unsupported situation.

TABLE 4.3: PERCENTAGE OF MOTHERS' INTENSIVE MOTHERING COMMITMENT BY COUNTRY

	U.S. *(N=22)*	*CANADA* *(N=22)*	*TOTAL* *(N=44)*
STRICT	41% (9)	68% (15)	55% (24)
FLEXIBLE	59% (13)	32% (7)	45% (20)

Breastfeeding Commitment

As previously mentioned, insofar as breastfeeding has been constructed as the ultimate infant feeding method, it has become a component of the dominant mothering ideology. The women in this project varied in their commitment to the ideology that breastfeeding is best. Some women (61 percent) were strongly committed to the ideology

of breastfeeding, such that breastfeeding was worthy of significant struggle and sacrifice. In contrast, other women (39 percent) simply considered breastfeeding to be one of several infant-feeding options. See Table 4.4 for a distribution of women's commitment to breastfeeding as well as the arguments they used to support their position. A woman's commitment to breastfeeding, rather than formula feeding, not only provides explanations for her behavior, but also illuminates the different ways in which women construct motherhood. Definitions of "good motherhood" are bound in these women's commitment to breastfeeding as they hold themselves and other women accountable for their motherly behavior.

TABLE 4.4: PERCENTAGE OF MOTHERS' COMMITMENT TO BREASTFEEDING	
Commitment Level and Arguments	*Percent of Mothers (N=44)*
Strictly Committed	**61% (27)**
Natural	70% (19)
Medical	56% (15)
Bonding	56% (15)
Promotion of Guilt	52% (14)
Flexibly Committed	**39% (17)**
Pragmatism	82% (14)
Success Story	47% (8)
Everyone is Different	71% (12)
Resistance to Guilt	53% (9)

I. Strict Commitment to Breastfeeding

The women in this project varied in their commitment to breastfeeding. At one end of the spectrum were mothers with a strong commitment to breastfeeding. These women felt that breastfeeding was the best infant feeding method for any child, especially their own. Sometimes these women struggled with breastfeeding and went to extreme measures in order to make sure that they were able to successfully feed their children breast milk, whether at the breast or through a bottle. Given their strong belief in breastfeeding as the ultimate source of infant nutrition and bonding, it is not surprising that these women were likely to negatively judge other mothers who did not breastfeed. These women can be understood as having a strict commitment to breastfeeding.

Although these women varied in the strength of their commitment to breastfeeding, all of these strictly committed women believed that breastfeeding was the best infant feeding option. Generally, these women tended to draw on arguments from the breastfeeding movement, but as mothers who have experienced infant feeding first-hand, their interpretation of breastfeeding differs from its institutional construction. The mothers adjusted their perspective of breastfeeding in light of their own lived experiences. For example, although they would argue that breastfeeding is best, these mothers acknowledged how hard breastfeeding actually is and they wanted more support for breastfeeding mothers.

Natural

Most (70 percent) of the women strongly committed to breastfeeding argued that it is the most natural way to feed a child. Some used essentialist arguments and

suggested that the primary purpose of having breasts is to breastfeed. For them, the decision of breastfeeding over formula feeding was a "no-brainer." Jordan, 39, from Canada, makes this case quite clearly when asked about why she believes breastfeeding is best. She says:

> Well first of all, God gave us breasts with milk for a reason. A very obvious reason, to my mind. And that's what it's there for. I know it's the best thing for my baby, hands down…I mean, to me it seems like the sensible, normal thing for a mammal to do, you know?

Using the claim that the biological purpose of women's breasts is to provide milk to their children, Jordan argues that it makes sense to capitalize on this natural process, as any mammal would do. Diana, 36, from Canada, follows this train of thought, that breasts exist to provide breast milk and says, "Yeah there was just no question for me. That's part of being a mom. That's what they're there for. That's what you use them for." Here, Diana not only essentializes women's breasts by stating that their purpose is infant feeding, but she also extends the importance of breastfeeding to be part of the definition of motherhood.

In addition to arguing that the biological purpose of breasts is to breastfeed, these women also argued that just by being natural, breastfeeding is good. For example, when asked about her reasons for breast rather than formula feeding, Taylor, 37, from Canada, says, "It wasn't really a, 'Let's go and do research' choice. It was just kind of subconscious, like, well, this is just the right thing to do, because it's natural, and I'm all about natural." Furthermore, Avery, 31, from Canada, says, "It's natural. So I was in the mindset that if it's natural, then it's got to be good." These mothers have likely picked up on the "natural is good" framing in the women's health movement, arguments resisting any medical (read male) intervention in the feminine experience of childbirth and

motherhood (Annandale 2009). These women, like other mothers committed to breastfeeding, contended that it simply makes sense to draw on this organic, naturally occurring resource to feed their child.

Sydney, 26, from the U.S., another woman with a very rigid commitment, had a slightly different take on the natural argument for breastfeeding. Coming from an evolutionary standpoint, she finds the idea of feeding her child another species' milk repulsive. When explaining why she breastfeeds her daughter Sydney says:

> This is the way you do it. This is what's natural. Not to get into the natural equals good fallacy but, you know what I mean. This is species-specific milk for a specific species, you know. This is my milk for my baby, so this is what I do.

It is likely that she developed this perspective because of her educational background in evolutionary science, but she also says she never wanted to give her child formula. Even when she considered a soy-based product, she was disturbed by the seemingly unnatural ingredient list. Sydney was the only mother to take such a scientific perspective, and although she is resistant to aligning herself with the "natural is good fallacy," she was mostly comfortable with breastfeeding because of its naturalness.

Most of the women committed to breastfeeding cited its naturalness, at least briefly, in their defense of breastfeeding. The breastfeeding movement does not explicitly take up this argument, although it is touched on in several activist frames (e.g., arguments that address the environmental benefits of breastfeeding). However, women still picked up on the contemporary discursive language that argues natural and organic materials are superior to processed products, and according to the dominant discourse of intensive mothering, women are expected to provide only superior products for their children.

Medical

Another rationale on which 57 percent of these mothers drew to support their commitment to breastfeeding was medical arguments and explanations. They would articulated some of the medical benefits of breastfeeding (many of which are promoted by breastfeeding activists) as explanations for their commitment to breastfeeding, such as the ways breastfeeding can help prevent a child from getting sick. Samantha, 28, from Canada, for example, says, "The immunities in breast milk help a lot with colds and, like, when kids are sick. They get less colds and less ear infections, which is a benefit of breastfeeding over formula feeding." Similarly, Avery, 31, from Canada, went back and forth when deciding whether to try to breastfeed her child. It was the possibility of reducing her child's chances of having asthma and allergies that convinced her that breastfeeding was what she wanted to do. She says:

> Well, the number one reason was the possibility of having my daughter's immune system or whatever -- have her little body be stronger and perhaps that she would not develop the bad allergies and asthma I had. So that was my number one motivation.

These mothers jumped at the opportunity to help reduce the likelihood that their child would face disease. They wanted to make sure they were doing all they could to raise a healthy, well-adjusted child. As Isabel, 32, from the U.S., stated, "it's the best and it's going to make him smarter and it's going to make him healthier and that's why I have to do it." Here, Isabel is drawing on the contestable proposition that breastfeeding increases an infant's intelligence and IQ. Although still used in some breastfeeding promotional literature, most recent studies have complicated the relationship such that significance between breastfeeding and IQ no longer exists (see Chapter Three).

Some of these women were very well informed about the medical benefits of breastfeeding, and were able to list most of the benefits cited by breastfeeding activists. However, most mothers simply said that breastfeeding was healthier than formula feeding and could only cite one or two explanations for that belief. This inability to articulate the specific benefits touted by medical arguments suggests that women are encountering this medical discourse, but are either not familiar enough with it to remember each of the details or do not feel it necessary to recall the details of advice from such a trusted source. Such a finding is not surprising given the complicated and multi-faceted nature of many medical research results.

Bonding

Mothers committed to breastfeeding were also sensitive to the argument that breastfeeding helps mothers bond with their children. Although a few of these women believed that bonding could occur with bottle feeding as well, most (57 percent) agreed that breastfeeding was an irreplaceable experience, forever connecting mother and child. Diana, 36, from Canada, describes this experience by saying:

> This is the most comforting thing. Your baby is snuggled up to your breast. Their nose is pressed into you and it's got to be the warmest, coziest thing in the world from the baby's perspective. I think the bonding for the mother being able to do that, it's just such a wonderful feeling.

Jasmine, 28, from Canada, has a similar take on this experience. She says:

> I'll never forget this. I'll never forget how, you know, he'll look at me when he's eating, you know, and he'll smile and he starts laughing. Like, I'll never forget that. It's just, it's totally different than, you know, me holding a bottle to him.

Both of these women describe breastfeeding as an incomparable bonding experience and one that is worth any trouble or sacrifice that may be experienced. Jordan, 39, from Canada, for example, had to pump for the first six months with her child before being able to establish a solid breastfeeding latch. But, she still describes the breastfeeding experience as "a special relationship between mother and child. It's just a different kind of bond than with the bottle." Making it through the six months of struggle was worth the effort, in her mind, because she was better able to connect with her child when was finally able to feed her from the breast.

This articulation, regarding the importance of breastfeeding for mother-child bonding, echoes breastfeeding movement arguments. In the movement frames, this argument was often embedded in statements regarding the benefits of breastfeeding to the mothers' and child's emotional health. These mothers spoke about bonding in a very emotional way, as the means to develop an incomparable connection with their child.

Promotion of Guilt

Most (52 percent) of the mothers strongly committed to breastfeeding desired a culture of breastfeeding that made it difficult for mothers to feel comfortable formula feeding their child. In fact, some of these women (26 percent) went so far as encouraging the promotion of guilt onto mothers who did not breastfeed their children. Similar to the cultural framing strategy used by breastfeeding activists, these women argue that breastfeeding, instead of formula feeding, should be the cultural norm. An example of this desire for a cultural shift towards breastfeeding is evident in Rachel's response to being asked whether breastfeeding is best. Rachel, 37, from Canada, says, "I think that

there is a *normal* feeding method and it's breastfeeding. It's normal. Best implies that it's the gold, but if you're okay with just silver, you could just do formula. Breastfeeding should be normal." Rachel does not want women to feel comfortable choosing formula for their children; she does not want them to assume that it is acceptable to "settle" for formula. In fact, Rachel specifically states that doctors should be encouraged to make mothers feel guilty for deciding to formula rather than breastfeed their children. She states:

> It's one of those things that people don't want to make mothers guilty about—about feeding their babies formula. So they don't tell them the health risks; that babies are more likely to become obese, more likely to get asthma, more likely to get type 1 diabetes—sorry, type 2 diabetes. And they don't tell them that, because they don't want to make them feel guilty. *But* if you went to your doctor and told them you had just taken up smoking, I'm sure he [sic] would sit back a half an hour and tell you how unhealthy it was.

Rachel's faith in breastfeeding is so staunch that she believes that the risk prevention rate of breastfeeding is equal to the risk prevention rate of not smoking. Furthermore, in order to discourage each of these behaviors, she supports the idea of doctors making mothers feel guilty for not choosing to breastfeed. This sense of accountability is a step further than the cultural expectation of breastfeeding.

Another extreme example of wanting breastfeeding to be a cultural norm is illustrated when Samantha, 28, from Canada, states that if she had dictatorial power, she would set a mandate requiring mothers to try to breastfeed. She says:

> I do think every baby should be breastfed. If I could make a mandate or something, I would…I just think they get so much from it that you'll never find in formula. The immunities for one thing, the stem cells for another. There's stuff you can never replicate in formula that's in breast milk and it gives kids such a good start.

Surely Samantha's idea of a mandate is radical; however, she does clearly want all women to breastfeed and want women to face some kind of social consequence for failing their children if they do not breastfeed.

Another example of a mother calling for social sanctions against women who failed to breastfeed includes Hailey, 39, from Canada. She believes that formula feeding should be a last, desperate resort, and chosen only under extremely constrained circumstances. Although she does not say that she thinks mothers should feel guilty for formula feeding, she does describe her own feelings of guilt when she was not able to establish breastfeeding with her first child. She says:

> Like, I thought, 'I'm not normal. I'm not a good mother. You know, obviously if I can't breastfeed, something's wrong with me.' I thought something was wrong with me and I didn't feel adequate, basically. Socially adequate, right, because everybody seems to be breastfeeding, right? So I thought, gee, I couldn't do it and—yeah, that's where the guilt came from. Like I wasn't normal, you know.

Hailey's comments demonstrate the kind of cultural pressure that some of these women want mothers to feel about breastfeeding. Furthermore, her experience suggests that in some circles, this type of expectation is already established, leading to Hailey's guilty feelings.

Making breastfeeding a cultural norm has several implications. If breastfeeding were a "normal" behavior, women would potentially have a much greater support system on which to draw when they experienced breastfeeding complications. There would be more women with breastfeeding experience to whom new mothers could turn for advice and understanding. However, women would also experience much greater pressure to breastfeed. Generally, there are social consequences associated with deviating from cultural norms; norms are established in order to socially control people's behavior

(Gibbs 1981). Although this could certainly increase the rate at which women breastfeed, it would also make mothers more vulnerable to criticism if they "failed" to live up to this standard.

These arguments illustrate the different ways in which mothers who strictly believed in breastfeeding defend and justify their infant feeding position. Some of these arguments draw on framing strategies from the breastfeeding movement while others are more specialized to the women's interpretations of their lived experiences. This finding demonstrates that although movement arguments may resonate with a particular audience, they will also be interpreted and negotiated in light of those people's own personal experiences. In this case, mothers used some of the activist framing strategies (i.e., medical advantages and cultural shifts). However, they negotiated and modified these arguments to better fit their own lived experiences (i.e., unable to specifically state all of the medical benefits of breastfeeding and demanding cultural support in their cultural shift).

II. Flexible Commitment to Breastfeeding

In contrast to the women who were strongly committed to breastfeeding as the best infant feeding method for themselves and others, some women (39 percent) were more flexible. Although these women sometimes agreed that breastfeeding could be the best infant feeding option, all of them were opposed to believing that formula feeding is bad. Often, these women specifically addressed the issue by stating that they recognize the benefits of breastfeeding but that in our contemporary environment, infant formulas

are made well and can offer a lot of freedom and choices for mothers. Generally, these women tended to have more faith in the medical community than mothers strongly against formula feeding.

These women who were flexible in their infant feeding preferences shared several arguments that defended their position. They addressed issues such as wanting the freedom and flexibility that formula feeding can provide mothers by allowing other people to feed the child. Other arguments include knowing a "success story" of a child who was formula fed with no negative outcomes and that every mother and situation is different and no one rule should always apply. Finally, all of the flexibly committed mothers were opposed to making mothers feel guilty for choosing any infant feeding method.

Pragmatism

Nearly all of these flexibly committed women (82 percent) agreed that a "happy mother is a good mother." They would say that if the stress of trying to establish breastfeeding is so difficult as to interfere with the emotional health of the mother, then it should be abandoned and mothers should not feel guilty for formula feeding their child. In fact, Jennifer, 28, from Canada, who fed her children a combination of breast milk and formula, regrets not switching to formula sooner with her first, colicky child, the way she did with her second child. She says, "I mean looking back, formula probably would have been better for me with my daughter. I probably wouldn't have been quite as frustrated and I could have given up a little bit more of the parenting roles to somebody else."

In fact, many of these women went into their childbirth figuring they might try breastfeeding, but allowed themselves the freedom to change their mind if it did not work out. For example, Lily, 36, from the U.S., says, "I went into it with the attitude like, this sounds like a good idea, but it won't be the end of the world if it doesn't work out." Similarly, Caroline, 31, from Canada, believed that although breastfeeding may be better, formula feeding is still ok. She says:

> I think it's kind of—it's great if it [breastfeeding] does work. I don't think it's the end of the world if it doesn't work out. I think I would have been okay if I had wound up having to give her formula.

And, when asked whether she thinks it really matters whether an infant is breastfed or formula fed, Avery, 31, from Canada, says:

> In the end, I don't think there's a big difference. I'd like to think that breast milk may have something in it that we haven't figured out yet, that's not in formula. But I don't know if that's true. But I think as far as if a baby is going to grow up healthy, I think both will contribute to a healthy baby.

These women, flexible in their breastfeeding commitment, believed that there should not be pressure or guilt against formula feeding. Therefore, these women looked at infant feeding method with a pragmatic approach and expected women to use whatever method makes sense in their individual lived experience. Even the mothers who wanted to breastfeed gave themselves room to "fail" and switch to formula. Their primary goal was to find the infant feeding method that worked best for them and their child. Such an understanding embodies a "good enough"[10] model of mothering.

[10] This term was coined by psychoanalyst Donald Winnicott (1953) who argued that the "perfect" mother who satisfies all the needs of an infant on the spot prevents him/her from developing. Rather, he argues that good-enough mothering, an imperfect approach

Success Story

The women who were flexible in their infant feeding beliefs usually knew healthy, well-adjusted children who were formula-fed and 47 percent of the mothers drew on those "success stories" as a defense for the decision to formula-feed. Sometimes the women themselves were raised on formula, other times they knew young children who were recently raised on formula and they could see first-hand that formula was a satisfactory alternative to breastfeeding a child. Natalie, 37, from the U.S., for example, was struggling with establishing breastfeeding and as she was deciding to switch to formula, she says, "I'm thinking, 'Well, I wasn't breastfed. My brother wasn't, you know.' I think we're fine." Natalie even considered her brother, a physician, "one of the smartest people" she's ever known and figured if he could turn out that smart and healthy, then her child will be just fine, even if formula fed.

Another mother, Morgan, 29, from the U.S., never even considered breastfeeding and had decided she would formula feed her children before they were even born. She says:

> I knew that I was formula fed, and my husband was formula fed and you know we're fine. We're never sick. You know, I know that statistically there are major benefits to breastfeeding, but—you know the ones of us that were formula fed, we all survived.

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where women allow themselves to "fail" gradually teaches a child independence (Winnicott 1953). This kind of argument is being presented again in popular forms such as parenting books titled *Good-Enough Mother: The Perfectly Imperfect Book of Parenting* (Syler and Moline 2007), and *Good Enough Mothers: Changing Expectations for Ourselves* (Marshall 1994). Such books have likely come in response to the popularity of the intensive expectations of attachment-parenting.

Therefore, whether as part of the decision-making process or as part of a justification for the decision that they made, the women with a flexible commitment to infant feeding would often reference "successful" cases of formula-fed children.

Everyone is Different

Most (71 percent) of the mothers with a flexible commitment to infant feeding method argued that every mother and every baby is different and one feeding method cannot work for everyone. For example, Emily, 28, from the U.S., says, "You know, every mother is different. They have their own reasons, so it's not really for me to judge." Likewise, Jennifer, 28, from Canada, says:

> I think every baby is different…And I think every situation is different too, I mean, you know. If you have a mom that's going right back to work at six weeks old, or something like that, how feasible is it for her to pump that much or to leave her work area or something like that to breastfeed? I mean it might not be an option…I think that parenting is so individualized anyway, you know, everyone has different opinions on everything when it comes to parenting, you know. And why wouldn't they have their own opinions on feeding. So, I think its part and parcel, you know, we've been surviving as a race for so long that obviously either way works.

Some of the women did believe that breastfeeding is the best way to feed a child; however, they continued to argue that it is the mother's decision regarding which method she chooses to feed her children. Audrey, 41, from Canada, for example, decided before the birth of her first child that she would "just try" breastfeeding. She did not describe this feeding method as something that she felt she had to do, but instead, as something that was worth trying. She says:

> To be honest, I really do feel that breastfeeding is the best way to go. For all of the reasons that I said that it works for me. At the same time, I do honestly recognize that it isn't going to work for everybody. So, while I might think that health-wise and financial-wise and bonding-wise, it's best

> to breastfeed, if it doesn't work it's ok. It's not the best thing for everybody.

Although Audrey ended up happily breastfeeding all three of her children, she understands that breastfeeding is not for everyone. In another example, Emily, 28, from the U.S., says, "I do believe the 'give it two weeks' method. Try for two weeks and if it doesn't work out, then make your decision to quit." Emily believes that mothers should, at the very least, *try* to breastfeed. However, unlike the strictly committed mothers, Emily does give women an out, without going to the extreme of encouraging formula from the start, just in case breastfeeding does not end up working well.

These women respect that a mother's and child's circumstances may affect a mother's ability and willingness to breastfeed and that those differences should be respected as explanations for whatever infant feeding decision women make. Therefore, even though some of these women were explicit in their belief that breastfeeding is best, unlike the strict mothers they acknowledge that in practice breastfeeding may not be best for every mother. Rather, these mothers recognized that sometimes formula feeding made sense.

Resistance to Guilt

Many (53 percent) of the women with a flexible commitment to breastfeeding discussed frustration with the stigma against formula feeding. They talked about feeling a lot of pressure from medical professionals, child-rearing literature, and even strangers in order to breastfeed their child. Caroline, 31, from Canada, a woman who breastfed, says:

> I mean, I think since I've had her I have noticed I feel like it's quite, like

> heavily pushed—breastfeeding. And I mean, I have friends who have really struggled and had supply problems and stuff, and are just really made to feel quite badly if it doesn't work out for them. That just doesn't seem right.

Although Caroline made the decision that she would breastfeed her children, she does not think that any woman should be pressured to make the same decision or that any mother should be made to feel badly for whatever decision she makes. Natalie, 37, from the U.S., a mother who decided to formula feed her child says:

> You've got to be careful of the nipple Nazis…they're sort of making you to feel like you're all—you know, you're *this* close to child abuse for not breastfeeding. Yeah, there are so many more things you can do that are going to help this child so much more than being breastfed. I imagine there'll be a shift at some point in the future, but you know, right now, if you just -- I think it's terrible what they do. I mean, they put so much pressure on, you know.

In fact, Claire, 36, from the U.S., sums up this perspective nicely when she says her advice to new mothers would be:

> To try breastfeeding, you know, but not to beat yourself up if it doesn't work. Some women just can't. Some babies won't latch. It just doesn't work or some women can't produce the milk that they're supposed to or some babies have allergies and they can't breastfeed and, you know. It just seems like we have this stigma if you can't breastfeed. You're not doing it naturally and, you know, you're missing out on something and you're not going to have this bond with your baby. And, there's just so much garbage out there that it's hard enough having an infant and then you pile on all this guilt too. I would just tell them to do what you can do. As long as your baby is gaining weight and is healthy, then don't worry about it.

These women with a flexible commitment to breastfeeding did not align themselves with the dominant breastfeeding ideology. They resisted the pressure to make mothers feel guilty, and refused to guilt themselves into believing there is only one way to properly care for a child.

These are the arguments women used to defend their flexible position on infant feeding. These women were unwilling to commit themselves to breastfeeding as superior than formula feeding, but instead considered the decision of infant feeding method to be an individual decision that is based on the lived experiences of the child and family in question.

Competing Ideologies

It makes sense that there would be a relationship between a woman's commitment to intensive mothering and her commitment to breastfeeding, particularly since intensive mothering demands that mothers breastfeed their children. Table 4.5 shows the distribution of women's commitment to intensive mothering by their commitment to breastfeeding. Here we see that the mothers with a strict mothering ideology were more likely to be strictly committed to breastfeeding and the women who had a flexible mothering ideology were more likely to be flexibly committed to breastfeeding. One part of women's commitment to breastfeeding is demonstrated in their expectations for other mothers. When the expectation to breastfeed extends beyond oneself, we can interpret it as part of a dominant mothering ideology. As previously stated, ideologies define the way we see the world and determine our expectations for our own and other people's behaviors.

The following sections outline the experiences of women who fell into each of these four categories: Strict Mothering and Breastfeeding, Flexible Mothering and Breastfeeding, Strict Mothering/Flexible Breastfeeding, and Flexible Mothering/Strict

Breastfeeding. These narratives articulate the dedication these women had towards intensive mothering and breastfeeding and the ways in which they were harmonious or dissonant.

TABLE 4.5: PERCENTAGE OF MOTHERS' BREASTFEEDING COMMITMENT BY INTENSIVE MOTHERING COMMITMENT (N=44)		
	STRICT MOTHERING	*FLEXIBLE MOTHERING*
STRICT BREASTFEEDING	48% (21)	14% (6)
FLEXIBLE BREASTFEEDING	7% (3)	32% (14)

I. Strict Mothering and Breastfeeding

About half (48 percent) of the women in this project had both a strict commitment to the dominant mothering ideology and were strictly committed to breastfeeding. For these women, breastfeeding is an integral part of being a "good" mother and worth any struggle or sacrifice to succeed. Mariah, 39, from Canada, fits this description. She had a very strong dedication to breastfeeding; so much so, that her commitment extended beyond her own circumstances to those of other mothers. Mariah did not have difficulties establishing breastfeeding with her children; however, she argues that a strong dedication to breastfeeding needs to be more common. She contends that if women had breastfeeding support, they could (and should) persevere through breastfeeding challenges. She states:

> The problem is that in our society we've created an atmosphere of, 'Oh, it's okay.' As soon as you have any kind of problem, you are not going to

> get support. You are going to get the, 'Oh, well, you know what, you gave it a good try. Formula is good. You were raised on formula, and you turned out okay.' And if you get cracked nipples, or if you've got thrush or if you've got mastitis—you know what, you're tired, you've got so much pain, you are going to give in to it. And that's the problem…They don't need a placating pat on the head, and 'Oh well, you tried.' They need support to be able to, to do their best to see it through. And Western society isn't really good with breastfeeding support.

Mariah argues that mothers need more breastfeeding support, but she does not want the kind of support that would encourage a mother to decide against breastfeeding. She opposes the possibility of mothers thinking that formula feeding their children is "okay." Instead, she wants families and doctors to push mothers through challenges and remain completely committed to breastfeeding. Mariah's very strong commitment to breastfeeding is a part of her commitment to "good" motherhood as defined by dominant discourses such that she expects other mothers to breastfeed. Such a paralleling of beliefs makes sense given that an expectation of intensive mothering is breastfeeding.

II. Flexible Mothering and Breastfeeding

At the other end of the spectrum from mothers like Mariah are mothers (32 percent) who are flexible both in their understanding of good motherhood and their commitment to breastfeeding. In contrast to the strictly committed women, women with a flexible commitment to infant feeding considered the method that they fed their child mattered much less than many other health care decisions. Particularly when asked, "How much does it matter whether an infant is fed breast milk or formula?" these women would often reply that it matters very little. For example, Natalie, 37, from the U.S., said, "Like, who cares? You know, I just don't know why it's such a big thing…I can't see it making, you know, that much difference." Similarly, Autumn, 23, from the U.S., said,

"In the long run, I don't think it matters. I think what matters is that the mother feels that she's taking care of her child." These women still considered mothers who formula fed their child "good" mothers.

Kim, 35, from the U.S., argues that "good" mothers are those who don't:

> …listen to every single thing everybody else says, you know? I've realized that, you know, every child is different, every mother is different, every situation is different. I used to be like, before children, 'I'll never feed formula'…but now we're having this feeding issue and we're moving to formula.

Therefore, Kim believed that "good" mothers are flexible. She even changed her commitment to what "good" motherhood means regarding infant feeding, and went from disapproving of formula feeding to believing that mothers have to do whatever makes sense in their particular lives. These women with flexible commitments to infant feeding and intensive motherhood resisted the dominant mothering ideology that articulates one superior method of infant feeding and one way to be a "good" mother.

III. Strict Mothering/Flexible Breastfeeding

A few (14 percent) of the women in this project had a strong commitment to the dominant mothering ideology; however, they were flexible in their commitment to breastfeeding. Morgan, 29, from the U.S., for example, drew from the dominant discourses in her description of "good" motherhood. When first asked to describe what she thinks makes for a good mother, she says:

> Oh, dear. I think that is a hard question because you could probably ask any mother if she is a 'good' mother and everyone says 'Yes.' But, obviously, there is a lot that goes into it and not everyone is really a very good mother.

She goes on to define what "good" motherhood means to her. She says, "I think you have to be able to stop and enjoy the time with your children, and just really try to connect with them everyday. And, you know, just being there." However, breastfeeding was something that Morgan hardly considered for herself and her child. While she was pregnant she read a couple of books about the experience of breastfeeding, but as her delivery drew near, she decided that she did not want to breastfeed at all. She describes her pregnancy as stressful with illness, back pain, and severe weight loss, and then she says:

> The hormone levels throughout the pregnancy just bothered the heck out of me. I just felt like I was insane and like I wasn't really myself and couldn't really think clearly at all. And so, I just thought, you know, I can't, I can't do this anymore. I wanted to have her and just focus on her and you know, feel like I had my body back again and my life back together. I just wanted to, you know, do the formula, be on a feeding schedule, get my body back to normal, and just start enjoying life again.

Therefore, in her effort to be a "good" mom, who could focus all of her energy on her daughter and give her the love and affection required by intensive mothering, Morgan decided that formula feeding would work best for her.

Other mothers in this category were also committed to intensive mothering ideology; however, they had also decided that breastfeeding did not have to fit into that model. Claire, 36, from the U.S., for example, was unable to establish a solid latch with her child. After several months of pumping and bottle-feeding, she came to realize that the stress of pumping was not worth the stress she was under and that by focusing her energy on caring for her child in other ways, she could better live up to the dominant standards of motherhood. She says of stopping pumping breast milk, "I had had enough. I was totally ready; it was just the right time." Furthermore, she defines "good" mothers

as those who are "as active as possible [with their children]. You just need to be involved in their life, to be there." Therefore, given her strong commitment to intensive mothering, Claire willingly stopped the pumping experience because for her, it was more important to spend quality time with her child than to feed her breast milk instead of formula. Faced with infant feeding or hormonal challenges, these women were able to remove infant feeding method from their definition of "good" motherhood, even though they remained committed to the dominant discourses of intensive mothering. These women adjusted their commitment to breastfeeding in order to meet their lived experiences and maintain their commitment to intensive motherhood.

IV. Flexible Mothering/Strict Breastfeeding

Only seven percent of the women in this project had a flexible commitment to mothering ideology while remaining committed to breastfeeding. Sydney, 26, from the U.S., for example, is one of the mothers who had severe complications establishing breastfeeding with her daughter. Because of a minor birth defect, her daughter had a very difficult time latching properly and it was weeks before she could feed at the breast. During this time, Sydney pumped milk every two hours, even after she went back to work, and her efforts to help her daughter properly latch to her breast took an extraordinary amount of time. Here she describes staying committed to breastfeeding regardless of the difficulties she experienced:

> So, I was pumping more than eight times a day and I can't even believe I did it. I mean honestly, I'm pumping eight times a day to feed this child, getting her up in the middle of the night, you know, to try to feed her. It'd be like, I'd start bare breast and that didn't work. And then I put her up to the nipple shield and then try that for a while…and then I pump whatever she didn't get, and it would be a lot, and then feed her with a bottle. So it

> was just like this -- it was ridiculous, like, I can't believe I did it. But, yeah, she's exclusively breastfed.

Sydney's commitment to breastfeeding was strong enough for her to push through the inability to establish a latch, a dedication she looks back on as unbelievable. She describes pumping and the efforts to establish a breastfeeding latch as exhaustive and so much of a struggle that when asked what advice she would give another mother, she says "Do as I say, not as I do. Don't make yourself crazy." Therefore, even though Sydney has a very strong commitment to breastfeeding for herself, she does not impose that standard on other mothers. Instead, as stated previously, she believes that "a happy mother is a good mother."

The women in this category were deeply committed to breastfeeding as the ultimate infant feeding method. However, they also argued that motherhood is hard and challenging and that sometimes there is no one ultimate method to be a "good" mother.

These narratives suggest that although mothering ideology and breastfeeding commitment are strongly related, women's negotiation of defining good motherhood for oneself and others and the lived experiences of breastfeeding do not always support each other. These patterns reveal that mothers adjust their ideological commitments in response to their lived experiences. Although most women's commitments "make sense" in that they are generally strict or generally flexible, some mothers face a contradictory situation in which they have to adjust their commitment to their ideologies when their lived experiences do not match their expectations.

Differences in Commitment to Breastfeeding

In this section, I examine the ways in which women differ in their commitment to breastfeeding. I begin with an analysis of women's commitment to breastfeeding and the length of time that they spent breastfeeding. Next, I look at differences in women's social characteristics as these vary with their commitment to breastfeeding. Finally, I examine the ways in which mothers interpret and explain their relationship with medicalization in light of their infant feeding commitment.

I. Infant Feeding Commitment and Time Spent Breastfeeding

Just as these women's commitment to breastfeeding varied across a continuum, the length of time that these mothers spent breastfeeding also varied. The major medical associations and government organizations in the U.S. and Canada recommend that mothers breastfeed their children for a minimum of six months with a preference of one year or more (AAP 2005; Boland 2005). Table 4.6 illustrates the length of time these mothers spent breastfeeding in relation to their commitment to breastfeeding.

TABLE 4.6: PERCENTAGE OF THE LENGTH OF TIME MOTHERS SPENT BREASTFEEDING BY THEIR BREASTFEEDING COMMITMENT

LENGTH OF TIME BREASTFED	*STRICT (N=24)*	*FLEXIBLE (N=20)*	*TOTAL (N=44)*
Less than 6 mos.	29% (7)	50% (10)	39% (17)
6 mos. – 1 yr.	38% (9)	35% (7)	36% (16)
More than 1 yr.	33% (8)	15% (3)	25% (11)

This table shows that of the mothers who were strictly committed to breastfeeding, 71 percent breastfed for more than six months while only 50 percent of

mothers who were more flexible in their breastfeeding commitment breastfed for that long. However, 29 percent of these strictly committed women breastfed for less than the recommended six months. Such a pattern highlights the differences between women's ideological commitments and the reality of their lived experiences. Many of the women who breastfed for less than six months either had complications in establishing breastfeeding and felt forced to switch to formula or they wanted to switch to formula to regain a sense of independence with their body.

Grace, 29, from the U.S., for example, had planned on breastfeeding for at least a year. However, she had several complications during her pregnancy, which led to her son being born two months prematurely. Although she tried to pump and provide her son breast milk while he was still in intensive care and then tried to feed at the breast after her son came home, she was never able to completely establish breastfeeding. She says:

> I enjoyed breastfeeding. I mean, it's really pushed in the hospital and stuff and I know it's got lots of nutrients and stuff for the baby. But, I had to switch to formula. I didn't really have a choice. Breastfeeding is a wonderful experience and if I have another one, I'll probably try to breastfeed again. I did what I could.

Grace was very disappointed that her birthing experience did not live up to her expectations and she had to make choices that she was sometimes uncomfortable with in order to make sense of her life under those constraints, including not being able to breastfeed her child despite her strong commitment to breastfeeding.

In contrast, a few (seven percent) of the mothers, despite their strong commitment to the idea of breastfeeding, never intended on breastfeeding up to or past the six-month mark. Anna, 31, from Canada, for example, described many of the benefits of

breastfeeding and argued that it was the best way to feed an infant. However, she began weaning her baby to formula during her fifth month. She says:

> Because, I really, honestly want my body back. I love breastfeeding, but really—like, it's come to point now. I enjoy it, but I'm looking forward to having her on a bottle. I don't know if that makes me a bad mother, but there you have it.

Therefore, Anna accepted the dominant discourse of breastfeeding regarding its benefits over formula feeding for an infant. However, she could not comfortably live up to the dominant expectations of infant feeding and breastfeed for at least six months. In this case, she had to shift her strict ideological commitment to breastfeeding so that it could match her own lived experiences, where she felt tied down and overwhelmed breastfeeding for longer than five months. She questioned whether she would be judged as a "bad" mother for not trying to completely meeting the dominant standard, however, she is also committed to making herself happy as well.

At the other end of the spectrum are mothers (50 percent of sample) who are flexible in their commitment to breastfeeding but breastfed their children for longer than six months. Madison, 36, from the U.S., for example, was flexible in her commitment to breastfeeding but still breastfed her first child for a year and her second child for seven months. Her advice to other mothers is to "Do what's right for you and your child, and do what works." In her case, she wanted to try to breastfeed her second child longer than seven months but it became too difficult between the breast pains and the challenge of breastfeeding while also caring for another young child. She says:

> I've just been having trouble with breastfeeding. So, I've been trying to introduce the bottle to her because I think I eventually will be doing formula. She really clamps down hard and it's just been painful. I thought about doing it for a year, but oh well.

Therefore, although Madison had considered breastfeeding for a year, we see the flexibility in her commitment as she allows herself room to change her expectations. She advises other mothers to do whatever method works best for them and she has willingly changed her goals based on the challenges of her lived experiences.

These narratives demonstrate the complexity of connecting mother's ideological commitments to their lived experiences. Some women who were strongly committed to breastfeeding were still willing to depart from the dominant recommended standards while other mothers with very flexible commitments did breastfeed long enough to meet the dominant recommendations. These findings highlight the importance of research that gives room for women to explain what their beliefs are and how those beliefs contest or support their behaviors.

II. Social Differences in Commitment to Breastfeeding

Although there was very little variation in social differences examined by the women's commitment to breastfeeding[11], there was a stark difference between the commitment level of mothers from the U.S. and mothers from Canada. (See Table 4.6 for the distribution of breastfeeding commitment by country.) Similar to the distribution of women's commitment to intensive mothering, we see that most (59 percent) of the mothers from the U.S. had a flexible commitment to breastfeeding while most (68 percent) of the women from Canada had a strict commitment to breastfeeding. Again, it is possible that the structural supports play a large role in women's ability to breastfeed

[11] Characteristics examined include age, race, number of children, and social class.

making it more likely for Canadian women to succeed. Therefore, U.S. women's more flexible commitment to breastfeeding is likely a demonstration of resistance to an ideology that is not structurally supported or a practical response to the structural reality of their situation. Despite government participation in the recommendations for breastfeeding (see Chapter Three), there are few U.S. governmental supports that encourage the success of women following that advice (e.g., paid and longer maternity leave, onsite childcare and/or breast pumping stations).

TABLE 4.7: PERCENTAGE OF MOTHERS' BREASTFEEDING COMMITMENT BY COUNTRY			
	U.S. (N=22)	*CANADA (N=22)*	*TOTAL (N=44)*
STRICT	41% (9)	68% (15)	55% (24)
FLEXIBLE	59% (13)	32% (7)	45% (20)

III. Medicalization

In this section, I examine the ways in which mothers interpret and explain their views of medicalization in light of their infant feeding commitment. See Table 4.8 for a distribution of women's commitment to breastfeeding by their support of a medicalized childbirth experience.

TABLE 4.8: PERCENTAGE OF MOTHERS' SUPPORT OF MEDICALIZED CHILDBIRTH BY THEIR BREASTFEEDING COMMITMENT			
	STRICT BFING (N=24)	*FLEXIBLE BFING (N=20)*	*TOTAL (N=44)*
ANTI-MEDICALIZATION	83% (20)	15% (3)	52% (23)
FLEXIBLE MEDICALIZATION	17% (4)	85% (17)	48% (21)

Strict Commitment

Most (83 percent) of the mothers who shared a strict commitment to breastfeeding also had a strong aversion to medicalized childbirth. Similar to their argument that breastfeeding is good because it is natural, they also believed that childbirth should be as natural as possible. Sydney, for example, had plans to give birth at a midwifery center. Although this birthing center had medical professionals on site, it offered a much more natural and feminist experience than that often found in hospitals. Drugs were only used if absolutely necessary, surgeries were rare, and mothers were given options in their labor and delivery experiences (e.g., walking around, water laboring, and squat delivery). She says, "this [pregnancy] is not a sickness, this is something natural, you don't need medical intervention."

Taylor, 37, from Canada, was another woman who never intended to have her birth in a hospital. After seeing a documentary on water births when she was 14 years old, she decided that was how she wanted to have her child. So after finding out she was pregnant, she started doing research on water births and she says:

> I couldn't find a bad thing about a water birth, basically. Your skin is like leather when it's immersed in water. It stretches more easily and reduces

> the risk of tearing. And I'm like, 'That's not a bad thing. Let's do a water birth.'

So, she went to a midwifery clinic and requested a water birth. Regarding the experience she says:

> It was brilliant. It was really good. And, the more research I do about hospital births, whew. Like seriously, for every 20 women I talk to about their birth experiences in a hospital, like, 19 are horrific and one is, 'Oh, I had a wonderful experience.' And, I think those odds really suck, personally…I felt that the midwives really listened to me, and not only really listened but they gave me my options in a non-judgmental way. They're like, 'You can do this, this, or this. These are your choices, and these are the risks associated with those choices. But, it's up to you.' And I really appreciated that.

Taylor sought out a non-medicalized childbirth after becoming enamored with the idea of the natural and sensual experience of a water birth. Having had that experience and then talking with other mothers who had had medicalized hospital childbirth experiences, she has become even more confident in her decision. She appreciated the ability to have choices and options in her experience that were supported by trained midwives and says, "I will always want a home birth. I'm so glad I did it at home." Taylor was able to remain in control of her entire labor experience.

A few of these women were not initially opposed to medical intervention; rather, they developed strong regrets after having disappointing hospital birth with one of their children. For example, Rachel describes her experience saying: "It was very, lie on your back for 12 hours. Induced. Kind of, 'Do as you're told,' 'Don't move' sort of thing. Very unpleasant experience, actually. I mean, I—I was totally turned off by it." In response to this negative interpretation, she ensured that her second childbirth experience was quite different. She says:

> So the second one, I had midwives and I had a home birth and it was completely different. It couldn't be more different. And it was awesome. I mean, I love both my kids equally, but I loved my second one's birth experience more, obviously.

Rachel describes resenting having her movements and options limited and being left with little decision-making power in her first experience whereas with the second, she had the freedom to move around and make herself comfortable. It was not until after a negative interpretation of her first experience that she began to resist medical intervention in her childbirth, although she was already strictly committed to breastfeeding even for her first child.

Similarly, when I asked Mariah why her first childbirth experience was "so bad," she explained:

> What wasn't bad about it? It was one of those where I felt powerless, like everyone told me what to do…They had me lying in a bed—all those things that I now know were completely wrong—like lying in a bed, on my back, with monitors on. And then, when the baby started showing signs of distress—that he wasn't getting enough oxygen, they put me on oxygen instead of telling me to get up and walk around.

Mariah ended up with an unwanted cesarean section with her first child and felt completely violated and frustrated with her experience. The second time around she was able to have a home birth. When asked how she came to that decision she said, "My first experience was so bad, *so* bad—I was so literally terrified of the idea of giving birth in a hospital again. Just, and not terrified in a physical way but just emotionally." The devastation associated with her first childbirth prevented her from wanting another medicalized childbirth and likely contributed to her general resistance to medical intervention and to her passion for breastfeeding instead of formula feeding. In fact, for her first child, she describes herself as being "ignorant" about the problems with formula

feeding and quit breastfeeding after a couple of months because it got "too tough." It was during the time between her first and second child that she "got educated" and developed both a very strong commitment to breastfeeding and resistance to medicalization.

These women tended to resist medical intervention both in their childbirth experiences as well as in the feeding of their children. Sometimes, however, they were unable to make that goal a reality. Several of these women, like Mariah, developed complications either during pregnancy or labor resulting in unexpected cesarean surgeries. These women often reflect on these experiences with remorse and sadness. For example, Samantha had planned a home birth with a midwife. However, she says:

> I had kidney stones, which I thought was labor. It turned out it wasn't, but I was almost 42 weeks and they induced labor. That caused more problems and my daughter's heart rate decreased and I ended up with an emergency cesarean. It sucked. The whole thing sucked….My midwife transferred and I ended up with an OB that I didn't trust or like. And I was really depressed after that. It didn't go very well.

Samantha intends to try for a vaginal birth after cesarean (VBAC) at home with her next pregnancy and "really hope[s] it works out next time." Particularly after having a negative reaction to their hospital birth experiences, these strictly committed women were even stauncher in their resistance to medical intervention, during childbirth or infant feeding.

Flexible Commitment

Most (85 percent) of the women on the flexible end of the infant feeding spectrum tended to be comfortable with medicalized childbirth experiences. Given that these women are less likely to oppose medical intervention regarding infant feeding it makes sense that they would be similarly comfortable with medical intervention with childbirth.

For example, when I asked Natalie whether she considered alternatives to a conventional hospital childbirth she said no, that it's "great if that stuff works for you, but yeah. We figured we were kind of—they know a lot more than I do. I'd rather go with their standard procedure." She trusted that the medical community had superior knowledge than she would otherwise have access to and she trusted that doctors and nurses would use that knowledge in the best interests of her and her child. Morgan also was very comfortable with a medicalized birth experience. She says:

> I had her at the hospital and I can say that that was the absolute best days of my like. I did get an epidural, you know, once I started feeling the pain, once I couldn't take it anymore. It was wonderful. We never really considered anything else…So, I never really considered otherwise, just because, I always felt like if there were, you know, big complications I would feel better being close to a major hospital that could help. And yeah, I would do that again because it was really good. I mean, I think it's neat that other people do other things, I just don't know that that's right for me.

Again, these women are flexible with their belief systems, recognizing that childbirth, like childrearing, is not a cookie-cutter experience and that as women and children differ, so do the methods and practices of childbirth that work for them.

Similar to the strictly committed women, some of these women also experienced complications during pregnancy and delivery. In fact, several of these mothers had (both planned and unplanned) cesarean sections because of challenges that developed during pregnancy. For example, after having a miscarriage and being told that she was unlikely to carry a child to term, Jennifer was dependent on medical authorities for her childbirth experiences. She used fertility monitors to achieve pregnancies and then both of her pregnancies were planned cesarean sections. She says:

> I didn't have a birthing plan. I didn't. I knew from the get go that, you know, that I wouldn't be able to have a vaginal delivery and that it would

> have to be a c-section. So, I didn't even go into, like, the Lamaze classes. I didn't do any of that sort of stuff because I knew it wouldn't be what would happen.

Similarly, Caroline planned to have a conventional birth in the hospital, but birthing complications resulted in an emergency cesarean section. She says:

> I was a little upset like, I briefly cried, but I was also sort of relieved because it was obvious that it wasn't happening, you know. So, part of me thinks it would have been nice to have, you know, that normal labor experience. I think the other part of me is kind of just like, 'Well, it wasn't meant to be.' And to be honest, if we have another one, because I had a c-section, now I have the option for an elective c-section and I think I would just go with a c-section next time…Like, if it didn't work the first time, I'm not sure it would work the second time.

Caroline's story demonstrates her trust of medicalization as she was counting on a "normal" hospital birth and she is faithful that even next time, it will be easier for her to simply trust the doctors for a surgical delivery.

Similar to the women who were generally opposed to medicalization, these women encountered unexpected pregnancy and labor complications that resulted in unplanned birth experiences. However, unlike the strictly committed women, these flexible women do not describe their experiences with a sense of regret and remorse. In fact, despite some sadness that Caroline felt when she discovered she was going to have a cesarean surgery, she is comfortable scheduling that birth plan for her next child. It is possible that this second group of women became more flexible in their infant feeding beliefs given the complications they faced during childbirth. Needing to depend on the medical institution during pregnancy and labor, these women became more receptive to the medical intervention and the ways in which having and raising a child may not always go according to their plan. This increased flexibility and trust in medicalization likely also affected their flexibility regarding infant feeding methods.

The mothers in this study seemed to align themselves in a consistent pattern regarding medical intervention with regard to both infant feeding and childbirth. Most of the mothers who were strongly committed to breastfeeding as their method of infant feeding tended to prefer a less medicalized childbirth experience. And of these strictly committed women who had a hospital birth, whether planned or unexpected, most reflected on that experience with remorse and regret. Furthermore, almost all of strictly committed women commented that they wanted a less medicalized childbirth experience next time. In contrast, the flexible mothers who did not feel strongly opposed to formula as an infant feeding option, tended to be comfortable with medicalized childbirth experiences. These women confidently planned their hospital births with faith that they would be well cared-for.

IV. Conclusion

In this section, I examined differences among women with regard to their commitment to breastfeeding. I first compared women's commitment to breastfeeding with the length of time they spent breastfeeding. Although many of the patterns were expected (i.e., those with a strong commitment to breastfeeding breastfed longer than those with a flexible commitment), the analysis also revealed the challenges some women experience that cause them to reconsider their ideological commitment in light of their lived experiences. In this case, some women were strongly committed to breastfeeding; however, after encountering challenges in their experiences, they revised their ideologies so that they could remain "good" mothers despite quitting breastfeeding.

We see the potential for this kind of revision in the comparison of mothers from the U.S. to mothers from Canada. Here, mothers from the U.S. were likely to be flexibly committed to breastfeeding, while those from Canada were likely to be strictly committed to breastfeeding. It is possible that for mothers from the U.S., the structural reality of their lived experiences has a strong impact on their ideological commitment. There are few little structural supports for breastfeeding mothers in the United States, suggesting that their flexibility is either an agentic resistance or a pragmatic response to the dominant discourse that pressures women to behave in a way that is neither structurally nor culturally supported.

Finally, in examining women's commitment to breastfeeding in relation to their acceptance of medicalized childbirth, we again see women's lived experiences altering their ideologies. Some women who had a challenging childbirth with lots of medical intervention (or even an cesarean) began to (more strongly) resist any form of "outside" interference in their childrearing. Therefore, they were strongly committed to breastfeeding as a natural and organic way to feed a child and were very resistant to having a medicalized childbirth after their negative experience. Once again we see the lived experiences of women reshaping their ideological commitments.

Conclusion

In this chapter, I addressed the different ways in which the mothers in this study understood "good" motherhood and how a commitment to breastfeeding "fit" with those mothering beliefs. The women tended to differentiate themselves in the ways they identified ideal motherhood. Some women were strictly committed to the dominant

discourse of intensive mothering while other mothers were more flexible in their definition of "good" motherhood. Similarly, the women in this study either strongly committed themselves to breastfeeding or approached infant feeding more flexibly, possibly preferring breastfeeding but not disapproving of formula feeding as an option. Among these groups of women, the women strictly committed to intensive mothering and to breastfeeding were likely to draw on arguments from the breastfeeding movement as they defended their position. The women who were more flexible in their views of motherhood and infant feeding preferences drew on more feminist or individualist arguments, promoting women's ability to choose what works best for her without judgment. Therefore, only the women who "bought into" the discourses of breastfeeding activists drew on the dominant discourses of the movement.

However, the patterns and contradictions between these women's health beliefs and behaviors demonstrate the complexity with which women behave and make decisions about motherhood. Although many of the women matched their ideological beliefs about mothering with their beliefs and behaviors about breastfeeding, other mothers had to adjust their ideological commitments given the challenges of their lived experiences. This chapter reveals that mothers are not simple receptors of the dominant discourses of their identities. Rather, many of these women adjust their ideological commitments to accommodate the challenges of their everyday lives.

CHAPTER V

CONCLUSION

Overview of Research Findings

This dissertation examines the relationship between the macro-level construction of infant feeding and the micro-level responses by the intended targets of those messages—mothers. Breastfeeding activism provides an appealing opportunity to examine multiple under-explored aspects of social movements including the ways in which activists vary their argumentative strategies, across organizations and across geographical locations in the same movement. Furthermore, in this project I connect these messages with the lived experiences of mothers and compare their responses to each other and the movement discourses.

I began this investigation in Chapter Three with a content analysis of a sample (N=200) of publicly available publications intended to persuade mothers to breastfeed, rather than formula feed, their children. My analysis yielded a comprehensive overview of common framing practices across lay, medical, and governmental organizations in Canada and the United States. However, this analysis also demonstrated substantial heterogeneity among the frames employed by the various organizations. The discursive opportunities available in each geographical location affected the kinds of arguments that were likely to be used by activists in either the U.S. or Canada. For example, organizations in both places were able to draw on medical authority and a culture of risky childhood in order to employ preventative health frames that use medical arguments and

presumed threats to children's future health. However, we see activists in the U.S. bound by a neoliberal culture that limits the resonance of community support frames, which call on the social responsibilities (of both the community and mothers) associated with breastfeeding.

Similar to these findings, this analysis also highlighted organizational differences in the use of certain frames over others. For example, lay activists were more likely than medical or government groups to use the formula risk and rights frames. It is probable that these activists had more freedom than those working in the institutional setting of medicine or government to decide what kinds of arguments were acceptable. As expected, medical and government organizations were most likely to draw on medical claims to make their persuasive arguments; but they also used baby-saving frames and some mother's health frames. Given the new paradigm of health that rewards and reinforces medical authority, it is not surprising that these two kinds of organizations, bound by their institutional position, would be limited in their strategies to a less radical approach than the lay activists.

In addition to contributing to the scholarship on frame variation, in this project I also advanced researchers' understanding of the unique strategies used by embodied health movements. For example, this project demonstrated the need to reconsider our conception of embodiment because in the case of breastfeeding, a mother embodies not only the purported health risks to herself but also to her child(ren). Such reconsideration will likely expand the kinds of movements included under the rubric of "embodied health movements." Furthermore, such findings are revealing to gender theorists studying the social expectations of motherhood as they confirm theoretical arguments about the

pressures of intensive mothering as a dominant ideology (c.f. Hays 1996). Many of the mothers in this project recognized the cultural expectations of intensive mothering, even if they were able to resist the pressure from those demands. Therefore, the standards of this kind of ideal motherhood are still established in both the U.S. and Canada.

These analyses also highlight the impressive boundary work and strategic coalitions that are characteristic of embodied health movements, insofar as activists simultaneously contest and ally with particular organizations. For example, we see lay activists drawing on medical authority in their baby-saving and mother's health claims to lend legitimacy to their position that breastfeeding is superior to formula feeding. However, these activists also worked against medical research that suggests formula is equivalent to breast milk. They use medical authority to develop their own expert identities on the particular health issue while simultaneously challenging that authority to better serve the aggrieved population. It is through working both inside and outside the boundaries of medicine that embodied health movements gain legitimacy. Therefore, activists in this movement will strategically align with and contest other participants in the movement depending on the particular message they are addressing. Although other social movements have used some level of this kind of boundary work, scholars argue that it is a critical component of embodied health movements (Brown and Zavestoski 2004).

The findings from this research, however, suggest that this kind of boundary work may also be a disadvantage to the movement. As these organizations strategically align, they must make compromises that sacrifice some of the original goals of those activists. For example, in the breastfeeding movement, we see lay activists ally with government

and medical associations against whom the "original" grassroots activists (e.g., LLL and the WHM) were working. Although they still contest these organizations occasionally, it could be argued that they have also sacrificed some of their authenticity by working with groups that are counterintuitive to their original goals. Similarly, groups like the USBC, which are government-sponsored, are working towards policy reformation that better supports breastfeeding mothers. These groups are then challenging the policies of their own hosts. This finding begs the question, can EHMs truly succeed or does the reciprocal co-optation that seems to occur require a sacrifice of ideals?

In Chapter Four, I used data from 44 in-depth interviews, collected in both Nashville and Toronto, in order to examine how the intended recipients of these dominant breastfeeding discourses responded to the constructions of infant feeding. I examined how mothers' constructions of "good" motherhood and breastfeeding intersect with, challenge, or reaffirm the infant feeding ideologies established by the breastfeeding movement. I found that mothers who were strictly committed to the idea of breastfeeding drew on the medical discourses of the breastfeeding movement but tended to reject the medicalization of childbirth. They would cite medical arguments about the potential health benefits of breastfeeding to the child and mother. For example, Anna, 31, from Canada, says that her number one reason for being committed to breastfeeding her daughter was because "I wanted to do what's best for the baby and, from everything I understood from my doctor and everything that I've read, breastfeeding is the healthiest option. So, that was the number one reason I wanted to do it." Even though Anna does not list any specific health benefits, she draws on the authority of her doctor and the

literature she has read to believe that breastfeeding is the healthiest food option for her child.

However, some of these women also drew on their own, non-dominant arguments for breastfeeding. As was illustrated in Chapter Four, Sydney, 26, from the U.S. argues that her milk "is species-specific milk for a specific species, you know. This is my milk for my baby, so this is what I do." Furthermore, women had arguments against breastfeeding that the activists were not addressing in most of their arguments. For example, Alexa, 29, from the U.S. says that she never planned on breastfeeding because of her body-image issues. She says, "Um, my boobs are really big and I've always had a big problem with that. So, the thought of my kid sucking on them, like, disgusted me." Therefore, although much of the discourse around breastfeeding is moderated by the arguments the activists use, these mothers still establish their own meanings with regard to breastfeeding.

Along the same lines, this study highlights the complexity between ideologies and lived experiences. Mothers' beliefs did not always match up with their behaviors. For example, several mothers (14 percent) were strongly committed to intensive mothering ideology but were not as strongly committed to breastfeeding. In fact, many of these women struggled with either the experience or the idea of breastfeeding and they felt they would be better able to intensively mother their children if they were not being held back by the challenge of breastfeeding. Therefore, these women were willing to modify dominant ideologies, in this case to remove the expectation of breastfeeding from the ideology of intensive mothering, in order to better match with their lived experiences. Another way in which these women demonstrated their agency was when mothers strictly

"bought into" the discourses of breastfeeding activists, including using medical arguments to justify their pro-breastfeeding stance, and were then likely to question medical intervention in childbirth. Therefore, they accepted medical authority when it came to defending their belief in breastfeeding; however, they rejected that authority when it came to interfering with their bodies during childbirth. Such findings illustrate that the macro-level discourses do, in fact, affect women's conceptualization of breastfeeding and motherhood. However, despite women's commitments to these discourses, their bodies intervene and the women must adjust their ideological commitments accordingly.

Finally, given the cross-cultural nature of this sample, I was able to dissect differences in women's responses based on their geographical locale. I found that the structural supports in Canada versus the United States affected the kinds of mothering and breastfeeding ideologies to which mothers committed themselves. For example, Canada provides many more legal provisions that support breastfeeding mothers, including 12 months of maternity leave, protection for public nursing, and universal health care that includes the cost of many midwives and lactation consultants. Therefore, mothers in Canada were more likely to be strictly committed to an intensive mothering ideology and strongly believe in the importance of breastfeeding. These commitments contrast with the experiences of many mothers in the United States who challenged the dominant discourses of breastfeeding and intensive motherhood. They demanded that women consider more than one "right" way to mother. However, it was also these women who had little structural support for their mothering decisions. For example, many of these women had only six weeks of maternity leave and were unsupported in

public breastfeeding. Therefore, given that the U.S. does not structurally support breastfeeding mothers very well, women may believe that expectations for protection and support are unnecessary or unreasonable.

Such cross-cultural findings enhance our understanding of the impact of culturally-specific structural supports on women's beliefs and behaviors. In fact, these findings illustrate the complexity of the causal relationship between culture and structure. It is likely that the kinds of structural supports available, by way of policies, affect what women do and believe and what activists say. In fact, a Statistics Canada study (Baker and Milligan 2008) found that an increase in maternity leaves for Canadian mothers meant more of them have met breastfeeding targets recommended by public health agencies. Increasing the job protected leave from six months to one year increased the percent of women, from 20 percent pre-reform to 28 percent post-reform, who breastfed their children exclusively for the recommended six month period. Therefore, the structural provisions available to women *do* seem to affect their health beliefs and behaviors with regard to breastfeeding. However, it is also likely that the belief differences in the U.S. and Canada shape the kinds of structural supports available to mothers, such that a neoliberal attitude in the United States hinders the passage of laws protecting breastfeeding mothers. The findings in this project demonstrate how challenging it can be for researchers to unpack this circular relationship.

Academic and Methodological Implications

The findings of my analyses have theoretical, empirical, and methodological implications for researchers of social movement framing, health social movements,

feminist theorists of motherhood, as well as activists in the social movement itself. I now discuss the major contributions in turn.

First, the research design I employed in this project directly responds to the need for comparative work in social movements (c.f., Benford 1997). In fact, for this project I was able to capture differences at both the cross-cultural/geographical level (i.e., examining activists in the U.S. and Canada) as well as at the organizational level (i.e., comparing lay, medical, and government activists). Such a comparative sample increases confidence in my findings and increases the generalizability to other similarly structured social movements, such as the anti-circumcision movement, the breast cancer movement, and the AIDS movement.

Second, this research demonstrates, convincingly, that we cannot assume homogeneity in framing strategies within a single social movement, as suggested by McCammon (2009) and Snow and colleagues (2007). In Chapter Three, I clearly demonstrate the differences in framing strategies used by activists across geographical location as well as across different organizations, illustrating the presence of frame variation. Furthermore, these findings support the arguments that a movement's discursive strategy is subject to a variety of contextual factors, including political and cultural opportunities (Ferree 2003; Klawiter 2008; and Koopmans and Stratham 1999) as well as the receptivity of the target audience (McCammon et al. 2004). Such findings have serious implications for how future research on social movement framing is conducted. More comparative designs are needed so that researchers can uncover similarities and differences across the multiple layers of a social movement. Although

comparative research is often challenging, the potential to better understand the inner workings of social movements warrants pursuing.

Third, the contemporary construction of motherhood, particularly with regard to infant feeding, demands an expansion of the meaning of embodiment. In this case, mothers clearly embody the expectations and outcomes of their children's health. Considering this finding may allow a range of new health social movements to fit into the categorization of "embodied health movements." Scholarship on the relationship between mothers' behaviors and fetuses is likely to fit in this expanded definition. For example, Casper's (2005) work on the politics of breast milk biomonitoring and Oaks' (2000) work on the social politics of smoking while pregnant would certainly fit in this definition of "pseudo-embodiment." In these comparative cases we have two bodies in one such that the bodily actions of mothers directly affect the embodied experiences of their fetus, much like the behaviors of mothers in this project affect the embodied consequences of their child(ren).

Additionally, this research highlights the ways in which activists in embodied health movements use strategic coalitions and do boundary work. The activists studied in this project simultaneously allied with and contested co-participants in their own movement, just as projected by Brown and Zavestoski (2004) and other theorists of health social movements (Hess et al. 2008; Brown et al. 2004; and Zavestoski et al. 2004). These researchers are only beginning to understand the unique nature of strategic coalitions and boundary work done by social movements. My project demonstrates that these methods are being used by movement activists and likely have consequences for the frames used as well as the success or failure of particular goals. Certainly, the more

knowledge gained regarding the strategic coalitions and boundary work done by social movements, the better researchers will be able to understand activists' strategies and predict and/or explain successes and failures of other movements.

A fifth major contribution of this research considers the relationship between macro-level discourses and their impact on the intended recipients of those messages. Rather than focusing only one level of analysis, as is typical in social movements research, this project connected the dominant discourses promulgated by the breastfeeding movement, with the lived experiences of women who are making and defending decisions about feeding their own infants. In this case, we see mothers both challenging and reaffirming the dominant discourses. Although much of Foucault's (2008; 1977) original work seemed to suggest that the targets of biopolitics were passive receptors to these messages, more contemporary work on these theoretical concepts suggest that the targets can be agentic. In fact, Rose (2007) argues for the possibility of "active biological citizens." He suggests that "biological citizenship requires those with investments in their biology to *become* political" (Rose 2007:149, emphasis in original). Therefore, not only are the recipients of biopolitical messages capable of being agentic, but they are also, as Rose (2007) argues, responsible for both challenging and working with the medical community to improve their illness experiences.

We see this biological citizenship demonstrated by the women in this project. Some women refused to accept that there can and/or should be only one way to succeed at "good" motherhood. Although they may have felt the pressure of the macro-level discourses, they were able to resist enough to consider themselves good mothers despite not living up to the dominant expectations. Whether these women failed to breastfeed

because of a struggle with their bodies or because they felt that they could be a better mother if not burdened by the stress of breastfeeding, these women challenged the dominant assumption that breastfeeding and ideal motherhood are inseparable. Other mothers, in contrast, were strongly committed to the dominant discourses of motherhood, many of which are reinforced by the breastfeeding social movement. They have committed to that definition of "good" motherhood with regard to their own behaviors as well as the behaviors of other mothers. Such findings reinforce our knowledge regarding women's agency in interpreting dominant arguments and remind scholars that women are not simply passive receptors to biopolitical efforts and are likely to respond to dominant messages in a variety of ways.

Finally, this project provides insight into the inner workings of the breastfeeding movement. Activists are likely to learn much from the interview data regarding the effectiveness of particular framing strategies on women's conceptions of infant feeding. In particular, they may better understand the challenges of connecting women's ideological beliefs with their lived realities. Also, it may be worth reconsidering how these organizations strategically align to determine whether the activists feel the compromises they are making are necessary for success or whether their goals are being lost in the shuffle of their coalitions. In contrast, they may find that the path to success is through some compromise such that some of the more "radical" ideals are left behind in order to present more palatable, and therefore persuasive, messages to their audience.

Limitations and Avenues for Further Research

Despite the substantial contributions of this project, some challenges and limitations remain. First, although this study compared the organizational differences in framing strategies, I did not fully capture inter-organizational dynamics. Interviewing leaders in each organization would be fruitful, as these data would highlight how activists come to make decisions about the framing strategies that they use. Through the interviews we might better understand why lay activist groups, presumably those groups most connected with the experiences of women, were the group most likely to draw on formula risk frames, which tend to have a strong normative and moralistic tone. Furthermore, investigating how activists see their work in relation to other organizations that are part of the same movement would highlight how movement actors think about their organization's individual role within the movement proper. For example, these interviews could highlight how activist organizations come to make strategic decisions regarding their framing in light of the strategies used by other organizations in the same movement.

Also potentially problematic is the fact that I focused on national level organizations as the units of analysis in my content analysis of organizational literature. I excluded any local or regional organizations; therefore, my claims are revealing for only a particular type of social movement organization. Including these lower-level organizations in future research could reveal, even further, how the discursive opportunities (likely via the geographical culture and/or the structural supports) even further affect the kinds of arguments that activists expect to resonate with their intended audience. However, it is possible that there is not much difference between the framing

strategies of the national versus local activist groups. In an interview with a Nashville obstetrician, I asked what kind of messages he presented to his patients about breastfeeding. What he said was in line with the messages of the general pro-breastfeeding medical community, including that breastfeeding was the best option for a variety of health benefits to both the mother and child. However, I also asked him how much he felt that breastfeeding really mattered, in the grand scheme of things. He said:

> In the overall healthfulness of the baby, it's, you know, it's important but probably of marginal importance. When you get to Third World countries it becomes far more important. The water they are mixing the formula with becomes an issue, you know. The dilution of the formula becomes an issue. But here in the United States, I think that it's important. I think it gives your baby a step up in terms of infectious disease and antibodies, and is generally going to be good growth material, but I would be surprised if the literature could really show more than a marginal benefit. But, I don't say that to my patients.

Therefore, it seems that even at the mediating local level, the dominant discourses are those most likely to be employed, even if there are some doubts in those arguments.

Similarly, this project's findings are limited by considering only organizational materials that are presented online. Although their presence on websites makes the potential audience of those documents nearly endless, it may not best capture the documents to which mothers are most frequently exposed. Therefore, interviewing a broader sample of mothers to see what documents they have encountered would show which documents, and therefore which arguments, are the most widely distributed. Furthermore, this data would enhance our knowledge regarding what frames are most strategically used. These kinds of findings would also contribute to the scholarship on how social movements work, including how activists make strategic decisions about what kinds of arguments to make available and how to distribute them.

The findings from Chapter Four are restricted because of sampling limitations. Although I made an effort to compare mothers from similar circumstances in Nashville and Toronto, a broader sample, from multiple cities, would be more likely to capture the differences linked to the women's geographical location. Future studies into the lived experiences of mothers responding to dominant discourses of breastfeeding should attempt to include a broader sampling base, across multiple cities and towns.

Additionally, despite my best efforts to create a diverse sample, many of the participants in my study were white and middle class. The sample used here lacks the necessary minority sample to adequately address racial/ethnic or social class differences in women's constructions of infant feeding. While stories of those minorities who were included in the sample reveal glimpses into the racialized or classed experience of motherhood, they are not sufficient to fully address these social differences. Increasing the diversity of future research samples is particularly important because we know that breastfeeding behaviors are moderated by race and socioeconomic status. For example, according to a 2005 U.S. Center for Disease Control survey, 77 percent of white mothers initiated breastfeeding while 61 percent of black mothers, and 81 percent of Latina mothers initiated breastfeeding. Such a discrepancy suggests that there may be some cultural differences connected with a woman's race that affects her breastfeeding behaviors. Similarly, a Statistics Canada project (Miller and Maclean 2005) found that women with more education or higher incomes were more likely to initiate breastfeeding. Future research should certainly attempt to interview additional minority mothers in order to more fully address racial or social class differences.

Furthermore, the research could be extended and further enhanced through longitudinal studies of women's conceptions of motherhood and infant feeding over time, examining the changes in a woman's perspective of breastfeeding while she is pregnant, shortly postpartum, and then a few months postpartum. Such findings would better address the causal relationship between women's interaction with the dominant discourses of motherhood and breastfeeding and their own lived experiences. This research would be helpful in assessing the ways in which any challenges women encounter, including a difficult childbirth or infant feeding challenges, affect their ideological commitments to a certain kind of mothering.

Such limitations present a roadmap of possible directions for further research and inquiry into the complex relationship between macro-level discourses of motherhood and women's reactions to them. Despite these limitations, however, this project presents considerable contributions to our sociological knowledge, particularly with regard to the policy implications.

Policy Implications

This study certainly has several policy implications. First of all, increased structural support for breastfeeding mothers is needed in the United States. As both this project and Canadian research (Baker and Milligan 2008) illustrate, longer protected maternity leave is critical to increasing the duration rates of breastfeeding. In addition to improved maternity leave, workplaces could additionally support breastfeeding through the provision of on-site childcare, so that mothers could take occasional breastfeeding breaks and nurse their children, or private pumping stations at work, where mothers could

securely pump and store their breast milk for later feedings. Such supports would allow women to contribute to the workplace while maintaining their goals for motherhood.

In addition to increased workplace supports, medical assistance is also likely to increase women's breastfeeding rates. Hospital staffs need not only encourage breastfeeding, but also provide true support to mothers who are trying to breastfeed. Along these lines, the World Health Organization launched the Baby-Friendly Hospital Initiative in 1991, where hospitals can achieve the designation as "baby-friendly" when they do not accept free or low-cost formula for distribution and they work to complete a variety of steps for successful breastfeeding. These steps include training all staff and nurses on the benefits of breastfeeding, having lactation consultants who are trained to address any breastfeeding questions or complications and can offer hands-on guidance, and encouraging immediate breastfeeding after birth as well as rooming-in with the infant. Official policies that would encourage hospitals to take at least some of these steps would likely increase breastfeeding rates as mothers are being truly supported by their medical community.

Additionally, legislation needs to be passed to protect mothers' right to breastfeed in public. Women should not feel stigmatized for public nursing; therefore, it should be illegal for them to be asked to leave a space, where they have a legal right to be, simply because they are breastfeeding. The USBC is working with state activists in order to change some of the local legislation in order to better protect mothers who want to nurse their children in public. However, many states in the U.S. lack any provisions that would support a mother's decision to breastfeed publicly.

Finally, it seems that more government sponsored support networks could increase mothers' ability to breastfeed. For example, hotlines and other 24-hour resources should be established for mothers to use when they are experiencing struggles. Such a provision would be particularly beneficial in rural communities where it might be hard for mothers to experience in-person support. These resources need to be widely advertised and well-funded in order to reap the maximum benefits.

In addition to these structural changes, several cultural changes are likely needed to make these policies most effective. Mothers need to feel that breastfeeding is culturally acceptable in order for them to feel comfortable pursuing it. However, as we have seen with the Canadian mothers, this kind of cultural support can be a double-edged sword. The mothers from Toronto felt *expected* to breastfeed, as a social responsibility to their community because it was the cultural norm and because there were purported positive outcomes for their community (e.g., reduced healthcare costs, better for the environment). However, these mothers also negatively judged other mothers who failed to live up to the expected standard. Creating this division among mothers is not likely to encourage the supportive climate needed to encourage breastfeeding, but rather may pit mothers against each other in "good" and "bad" camps. Similarly, the scare tactics used by some of the U.S. breastfeeding promotions, including those comparing formula feeding with riding a mechanical bull while pregnant, put unnecessary pressure on women to breastfeed by creating an environment of guilt and moral responsibility. It seems possible that women can be encouraged to breastfeed yet supported in either infant feeding decision that they make, for whatever reasons they make them. The responses to many of the women in this project demonstrate a desire for this cultural flexibility. Their

stories illustrate the conclusion that although breastfeeding may provide a variety of benefits and should be encouraged and supported, mothers also have to make decisions that make sense for their lives.

APPENDIX A

Interview Guide

1. Family.

    a) In what year were you born? Where did you grow up? How many bothers and/or sisters do you have?

    b) Tell me a little about your parents. [Probes: What did your parents do for a living? Do they live near you now? How often do you see them? Do you have a close relationship with them?]

2. School.

    a) What is the highest level of education you achieved?

        a1) IF WENT TO COLLEGE: Where did you go? What did you study?

        A2) IF DID NOT FINISH HIGH SCHOOL: Did you earn a GED?

3. Work history.

    a) Do you currently work for pay?

        a1) IF WORK OUTSIDE HOME: What do you do for a living?

            1.2) Who looks after your child while you're at work? How did you decide on this arrangement?

            1.3) Did you take off work after the baby was born? If so, how long? How did you decide to do this?

        a2) IF STAY AT HOME: How did you decide to not work outside the home? When did you make this decision?

            2.2) Do you plan to work out the home later in the future, "as the kids grow up"?

            2.3) Do you participate in any volunteer/ unpaid work?

4. Relationship.

a) Tell me about the baby's father. (Probe: age, race) What is your relationship with him? (PROBE: still romantic, living together, married, not together)? What does he do for a living?

b) What kind of father is he? How would you describe the relationship between the child and his/her father?

c) What is his family like? Are you close with his family? How often do you see them?

5. Religion.

a) What kind of religious beliefs did you grow up with?

b) Do you still follow that? If not, then what do you believe now? (If beliefs changed when did this change occur?)

c) IF CHRISTIAN: What denomination of Christianity?

d) How often do you attend religious services?

6. Becoming a mother.

a) When did you first find out you were pregnant? How did this make you feel? Was this pregnancy planned or a surprise?

b) How did the father respond? Family? Friends?

c) How many children do you plan to have? [Did you/Will you] give birth in a hospital or with a midwife? How did you make this decision?

d) What do you think makes for a "good" mother? What do you think made you look at it that way? How do you recognize a good mother?

e) How do you think your own experiences in life, like the way you were raised, influences the way you will take care of your child? How so?

7. Infant Feeding Decision.

a) Every mother has to decide what to feed her baby. What have you decided to feed your child? How did you come to make this decision? When did you make this decision? Did you ever doubt that this is the right decision for you and your child?

b) Did you talk with anyone about whether to breastfeed or formula feed? (Prompts: Mom, sisters, friends, doctors, TV) What did they say? Did you listen to any one person and/or source more than others? If so, why?

c) What does the baby's father have to say about breastfeeding or bottle feeding? What role has he played in making your decision?

d) What about your own mother? What role did she play? Did you discuss this with her? What did you talk about? What advice did she give?

e) Do you know whether you were breastfed or given formula when you were an infant? Do you know whether your (brothers/sisters) were breastfed?

f) Have you consulted any pamphlets, websites, or other informational sources to get advice about how to feed your infant? What have these sources suggested? What do you think about their advice? How did their advice make you feel?

g) Have you consulted any magazines, books, or paid special attention to certain TV programs to get advice about how to feed your infant? What have these sources suggested? What do you think about their advice? How did their advice make you feel?

h) Do you know of any celebrities who speak out on infant feeding issues? If so, what have these people said? How did you find out about it? What do you think about it?

i) Did you get any advice from doctors or nurses? If so, what did they say? How practical or useful was this advice? How did this advice make you feel?

j) Did you take any childbirth or parenting classes? Did they offer any advice or information about infant feeding? If so, what did they say? How practical or useful was their advice? How did this advice make you feel?

k) Did you speak with a lactation consultant or other infant feeding specialist while you were at the hospital? If so, what did they say? How practical or useful was their advice? How did this advice make you feel?

l) What is the best advice about breastfeeding/formula feeding you received about feeding the baby? What was the worst advice? What advice was most influential in making your own decision to breastfeed or bottle feed? Why?

m) What about breastfeeding in public, what do you think about it? What kind of situations would you consider to be "public" with regard to breastfeeding (probe: restaurant, family dinner at someone's home, etc.) What have you heard other people say about this? What do you plan to do with regard to feeding in public? How do you think you'll respond to this experience?

8. Response to discourse.

a) Do you think there is a "best" infant feeding method? (Probe: for every baby, does it depend on the situation) If so, which do you think is best? Why? Have you always felt this way? How did you come to believe this? How much do you think it matters that an infant is fed breast milk or formula?

b) What infant feeding method do you think is best for the mother? Why?

c) Have you heard people say that "breast milk is best" for the baby? How do you feel about that? How do you respond to this statement? Does this statement affect the way you feel about feeding your own child? How so?

d) Do you know whether the U.S./Canadian government has a recommendation for infant feeding? If so, how did you find out about it? What do you think about it?

e) Do you know whether the state of Tennessee OR the city of Nashville has a recommendation for infant feeding? If so, how did you find out about it? What do you think about it?

f) Have you heard of La Leche League? Do you know what their recommendation is for infant feeding? If so, how did you find out about it? What do you think about it?

g) Do you know whether the any medical professional organizations, like the American Medical Association or the American Academy of Pediatrics has a recommendation for infant feeding? If so, how did you find out about it? What do you think about it?

h) Do you know whether your health insurer has a recommendation for infant feeding? If so, how did you find out about it? What do you think about it?

i) Are you familiar with the WIC program? Have you or do you intend to participate in that program? Do you know whether they have an infant feeding recommendation? If so, how did you find out about it? What do you think about it?

9. Infant feeding Experience.

a) Has the experience of breastfeeding/bottle-feeding been different than you expected it to be? If different, in what ways?

b) Do you (plan to) pump breast milk at work? At home? If so, what is this process like? How does it make you feel? What kind of pump do you use? How did you get it?

c) IF RESPONDENT TRIED BFing BUT WAS NOT CURRENTLY: How did you feel about having tried to breastfeed? How long did you breastfeed? Why did you stop? Did your experience meet your expectations? How did you feel after you tried and couldn't?

c2) Did you ever breastfeed in public? How did you feel about that?

d) IF RESPONDENT IS CURRENTLY BF: How do you feel about your ability to breastfeed? Does your experience meet your expectations? Have you ever fed the baby anything other than breast milk? (Probe: details on what else and under what circumstances) If so, how long did you just breastfeed the baby before you gave the baby something else?

d2)Have you ever breastfed in public? How did you feel about that?

e) IF NEVER BF: How do you feel about formula feeding? Do you wish that you had tried to breastfeed?

f) If you have other children, what do you think you will do? How come?

g) Since you've been a mother, has anyone criticized you for your feeding style? Who, when, how why? How did you respond to this?

h) What advice about breast or formula feeding would you give to a woman about to become a mother?

10. Is there anything else you'd like to discuss that seems relevant but was not addressed in this interview?

11. How many people live in your household? _____

12. What is your current age? _____

13. How old were you when you had your first child? _____

14. In what neighborhood do you currently live? _____

15. What is your race/ethnicity? (Please check all that apply.)

[ ] African American/Black
[ ]Caucasian/White
[ ] Native American/American Indian
[ ] Asian/Asian-American
[ ] Hispanic/Latino(a)
[ ] Other (please specify):
_____

16. What was your household income from all sources last year?

[ ] Less than $30k
[ ] $30k - $64k
[ ] $65k - $99k
[ ] $100k - $149k
[ ] $150k - $199k
[ ] $200k or more

13. Please initial here stating that you received $10 cash for participating in this study:
_____

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