

Breastfeeding's emotional intensity: pride, shame and status

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<1>Breastfeeding's emotional intensity: pride, shame, and status¹

Lisa Smyth

<2>Introduction

'It's time that we abandon simple solutions and simple slogans, and grapple with the nuance' (Hinde, 2017)

Breastfeeding has become a major global public health priority, with concerted efforts well underway to raise rates across the world (World Health Organisation and Unicef, 1989; World Health Organization, 2003). However, only 37% of infants on average are exclusively breastfed at six months in low and middle-income countries where the protective effects of breastfeeding for infant and child health are well known. Over 80% of infants are initially breastfed at birth in high-income countries but by the end of the first year, this has dropped to an average of 20%. The UK has one of the lowest rates in the world, with less than 1% of infants breastfed at 12 months in 2010 (McAndrew et al, 2012), in contrast to 27% in the US and 35% in Norway (Victora et al, 2016). The relationship between breastfeeding and global economic inequality is clear from the recent comparative work carried out by Victora et al, which demonstrates that 'for each doubling in the gross domestic product per head, breastfeeding prevalence at 12 months decreased by ten percentage points' (Victora et al, 2016:477).

Local inequalities also shape patterns of breastfeeding. The relationship between rates of sustained breastfeeding and patterns of inequality are well known within the UK (McAndrew et al, 2012). Those most likely to breastfeed are mothers from all minority ethnic backgrounds, and women aged 30 or over in managerial or professional occupations with educational qualifications beyond second level (McAndrew et al, 2012). Regional dynamics are also significant; Northern Ireland has the lowest rates of breastfeeding of the four UK countries, and consequently the world.

Public health researchers have examined the relationship between breastfeeding attitudes and social inequalities (Miracle and Fredland, 2007; Strong, 2013), the physical challenges to breastfeeding (Kelleher, 2006; Ryan, et al, 2013), and the effects of medicalization

(Thompson et al, 2011). Emotional support from family and friends (Wambach and Cohen, 2009) and practical support from health professionals, male partners and employers is important for developing effective interventions to improve breastfeeding rates (Chuang et al, 2010; Dykes and Flacking, 2010; Van Wagenen et al, 2015). These studies show that infant feeding practices are shaped by interpersonal and more general, public social relations (Callaghan and Lazard, 2011; Dowling et al, 2012; Dykes and Flacking, 2010). What is less well understood is how underlying social processes of status inequality, anxiety and shame shape infant feeding orientation. This chapter examines this connection by looking at the ways in which status anxiety experienced through shame makes infant feeding an emotionally intense feature of early mothering (Taylor and Wallace, 2012b).

<2>Status anxiety

Our health and wellbeing are shaped by our socio-economic class, and by our social status. While economic class is an important form of inequality, it works together with status, which is a less tangible but powerful form of social differentiation (Turner, 1988). The social theorist Max Weber defined status as 'a specific, positive or negative, social estimation of honour' (Weber, 1978:932). This 'honour', or esteem (Brennan and Pettit, 2004) is attached to identities which are ascribed to us because of our gender, ethnicity, or age, as well as the identities which we achieve, for example through education, sport or music. Status takes objective and subjective forms and involves public recognition of esteem, for instance through number of 'likes' on Facebook and our perceptions of how well others regard us as we perform our social roles, such as mother or friend.

The effort not to lose esteem by 'falling behind' or 'losing face' is a crucial motivation that shapes what we do and how we feel about ourselves (Goffman, 1971[1956]; Frank, 2007). Being able to meet the ordinary standards of our social context is an everyday priority, if we are to avoid feeling bad about ourselves (Frank, 2007). Having a sense of what is expected of someone 'like me', and a record of behaving accordingly (Stewart, 1994) is crucial in securing or maintaining status.

These felt estimations of esteem tend to focus on our style of living relative to the people around us, rather than how much income or wealth we might have. For example, we might

seek esteem from the location and décor of our home, style of dress, use of language, musical taste or family size (Chan and Goldthorpe, 2007). A young woman's expectation of how she would be esteemed for the way she dresses when she goes clubbing is different from how she might expect to be esteemed for how she dresses while caring for her young children.

We are all caught up in these endless processes of judging each other and ourselves in the light of wider expectations about people 'like us' - recognizing, withdrawing, and claiming status in the form of esteem as we go about our daily lives (McBride, 2013). We rely on status symbols to do this, such as dress, language, and by showing how well we meet social expectations through the competence we display as we act, for example as a new mother (Sunstein, 1996). However, displays of status symbols or competent role performances cannot guarantee status, and the uncertainty generates a pressure on our everyday behaviour (Goffman, 1951). Anxiety about our status becomes severe when a social role combines incompatible expectations. The intense pressure experienced by mothers in paid employment goes beyond the practical strain of juggling paid and unpaid work in societies where the norm of the male breadwinner is strong. Mothers in employment routinely meet expectations that the good worker is totally devoted to employment, while the good mother is devoted to raising her children, these tensions can have significant effects on job/career prospects, wellbeing, and family life (Blair-Loy, 2003; Ridgeway and Correll, 2004; Lewis et al, 2008; Benard and Correll, 2010).

While status and economic class may be closely intertwined, they work differently and may have distinct effects (Turner, 1988). Rather than thinking of status simply as the cultural dimension of class (Bourdieu, 1984), this approach treats it as a distinct social mechanism through which we feel ourselves to be esteemed, compared to the people around us whose opinion of us shapes our sense of who we are (Chan and Goldthorpe, 2007; Appiah, 2010). Our 'felt perceptions of rank' are at the heart of the status order, and they directly shape our sense of our own and other peoples' social worth (Turner, 1988:4).

<2>Status and emotions: pride and shame

We register our subjective perceptions of our status as emotions, whether in the form of pride in our ability to win the admiration of our peers, relief in managing to 'pass' as relatively competent in our social roles, or shame as we perceive that we have failed to measure up. Emotions such as anxiety, guilt, shame and embarrassment register negative evaluations of ourselves and our relative social status. As Taylor explains:

'... in experiencing any one of these emotions the person concerned believes of herself that she has deviated from some norm and that in doing so she has altered her standing in the world. The self is the 'object' of these emotions, and what is believed amounts to an assessment of that self'
(Taylor, 1985:1).

Negative self-assessment operates through these emotions, and we may feel shame when our inability to meet certain normative expectations is exposed (Lewis, 1995). Shame involves a sense of unintentional self-exposure that is experienced in embodied ways, either through blushing or some other physical indicator of one's dishonour (Lynd, 1958). Williams argues that shame is imagined in terms of nakedness and sexual exposure, which involves uncontrolled and improper revelations, and a desire to disappear (Williams, 1993). However, shame isn't only the feeling of being discovered displaying our actual or symbolic 'nakedness': we can experience shame also by imagining such discovery, and feel diminished in our own eyes as a result. Shame focuses on what we feel that we are, while guilt focuses our attention on what we have done to others, and calls for some form of reparation. This means that we can feel both guilt and shame about the same action. Guilt focuses on others rather than on the self, whereas shame focuses on the self, which provides us with some understanding of who we seem to be, how we relate to others, and how this fits with what we hope to be. This allows that we might be able to recreate ourselves as a result (Williams, 1993:93).

Shame has been described as the 'premier' social emotion in evaluating the relationship between the self and wider social and moral norms because of this quality. The experience of shame, or fear of shame, indicates our perception that we may lose all esteem, be cut adrift, and no longer entitled to a position in the social order (Scheff, 2000). Our sensitivities to the subtle dynamics of social status lead to anxiety about the possibility of shame, and our constant anticipation of it motivates our actions. This may explain why people who are

routinely and objectively considered to be of low or negative status such as women or racialised peoples, might try to transform their 'deeply discrediting attributes', (Goffman, 1963:13) into less 'shameful' forms to claim some social esteem, for example by lighten their skin tone (Scheff, 2000). In doing this, discredited agents recognise the norms which convey status, and paradoxically seek to claim that status by transforming their 'shameful' bodily features, however unsuccessfully (McBride, 2013).

<2>Status anxiety, shame and breastfeeding

Mothers are confronted with these paradoxes of status as they face the problem of how best to nurture their babies in the early days and weeks following birth. The normative context of early mothering is highly complex and contested, and although high quality infant care is defined in terms of maternal breastfeeding (Marshall et al, 2007; Wolf, 2007), the threat of shame from multiple sources is ever-present (Murphy, 1999). How to gain esteem for the quality of one's mothering is not at all straightforward (Phoenix et al, 1991; Warner, 2006; Smyth, 2012). Public debates about breastfeeding tend to include much broader tensions over expectations of femininity and female sexuality in motherhood (Carter, 1995), and the priority of 'natural' or scientific approaches to care-giving (Apple, 1987, 2006).

There is a conflict between expectations. On the one hand, there are Victorian gender norms around female sexual modesty (Carter, 1995). On the other hand, there are expectations that breastfeeding is the quality hallmark of early care giving. This generates concerns that the distinction between the maternal and the sexual is at risk of breaking down in breastfeeding (Blum, 1999; Stearns, 1999; Earle, 2003). These anxieties resonate with Mary Douglas's well-known argument that efforts to maintain an ordered society, for example by separating the sexual and the maternal are often symbolised through fears of bodily 'pollution', especially the transfer of bodily fluids. She says, '[i]t is not difficult to see how pollution beliefs can be used in a dialogue of claims and counter-claims to status' (Douglas, 2002 [1966]:4). Anxieties about this tension in breastfeeding seem to be driven by this process, particularly among people with low or negative objective status who struggle to demonstrate their commitment to the social order.

Feminist debates have only recently addressed questions about the relationship between breastfeeding and gender equality. This reflects unease with breastfeeding based on the historic association with maternalism (Raphael, 1976), and the rival feminist political principle of women's choice (Van Esterik, 1994; Carter, 1995). Feminism did not previously regard feeding babies with infant formula as problematic because it makes some redistribution of domestic labour possible by allowing fathers to be involved in 'the more gratifying aspects of parenting' (Maher, 1992:8) (see Tomori Chapter 6 on nighttime feeding).

Early feminist work criticised the close relationship between manufacturers of infant formula and healthcare providers for the way this powerful alliance limited women's choices (Palmer, 1993). The more recent intensification of breastfeeding advocacy, and the take-up of Unicef's Baby Friendly Hospitals Initiative (World Health Organisation and Unicef, 1989; see Entwistle and Tedstone), has weakened the power of providers of infant formula. Feminist attention has shifted towards considering whether and how breastfeeding promotion might itself have become a form of social control with which contemporary mothers must grapple (Knaak, 2010; Martin and Redshaw, 2011). Specific concerns are raised at the ways women at the lower reaches of the social gradient tend to be a target of advocacy work (e.g. Carter, 1995:20). Recent feminist work highlights the significance of carefully developed breastfeeding support for gender equality, and supporting sexual and intimate citizenship as an important dimension of women's autonomy and reproductive justice (Lister, 2002; Smyth, 2008; Smith, 2012; Stearns, 2013).

However, the moral expectations promoted in current breastfeeding advocacy face criticism (Knaak, 2010; Hausman et al, 2012). Taylor and Wallace argue that contemporary breastfeeding promotion tends to trigger shame in new mothers rather than guilt, with potentially destructive consequences (Taylor and Wallace 2012b:77). They argue that the shame provoked by breastfeeding campaigns is unlike the guilt which public health campaigns otherwise often rely on to change behaviour. Breastfeeding promotion tends to directly target the moral status of the embodied, gendered and sexualised self. Esteem is associated with breastfeeding mothers who 'successfully' put an intimate, sexualised and vulnerable body part to work for frequent care giving. This sets a high standard for early

motherhood at an already strained time, as new relationships are established, responsibilities taken on and care routines worked out.

Taylor and Wallace argue that women experience shame for not breastfeeding, or not breastfeeding enough, rather than guilt. Women who intend to breastfeed but for a whole variety of reasons find themselves unable to 'judge themselves as deficient: bad mothers, failures' (Taylor and Wallace, 2012b:85). The rest of this chapter develops this analysis by exploring experiences of shame among women who participated in a study of early motherhood carried out in 2009-2010 (see Smyth, 2012). This study aimed to examine not breastfeeding specifically, but how norms of selfhood shaped maternal experience across two sites in the UK and US: Northern Ireland and Southern California. Strong patterns of traditional values are evident in both sites, including belief in God, respect for authority, nation and the patriarchal family. They differ in attitudes to diversity, equality and self-expression, with Northern Ireland having one of the lowest rates of toleration for diversity and support for self-expression in the English-speaking world (Inglehart et al. 2000:29). Consequently, these two sites were identified as potentially promising contexts for exploring complex patterns of role interpretation.

Twenty mothers, mostly middle-class, were interviewed in each site. What follows focuses on the Northern Ireland sub-sample, so that the UK policy context can be more fully considered. Unprompted reflections on experiences with infant feeding and responses to pressure to breastfeed are examined below, guided by sociological literature on the moral, self-evaluative quality of shame. The analysis explores how unsolicited discussion of breastfeeding focused on feeling diminished in the eyes of significant others for breastfeeding in inappropriate places, not breastfeeding enough or not breastfeeding at all. Significant others included healthcare professionals, male partners, their own mothers, friends and women in their families. The ways that women felt diminished in their own eyes is also discussed, as problems with establishing or sustaining breastfeeding meant that they saw themselves as having failed to become the mother they hoped they would be.

<2>The pride and shame of infant feeding

'I was definitely, definitely proud of myself when I did all the breastfeeding and that. I definitely felt like I'd done a good thing. It wasn't easy, but I did it.'

(Anita², British, middle-class, full-time mother).

Unsolicited explicit expressions of pride and positive self-evaluation at having established and sustained breastfeeding were commonly expressed in interviews. This demonstrated a clear understanding of the expectations of new mothers, and a feeling that they were performing well and entitled to feel good. Such feelings of pride were often hard-won following difficulties, including the pain of cracked nipples and mastitis, and feeding when other people are present, whether visiting family members or strangers in more public places.

Shame about one's self as a mother was also commonly expressed when discussing feeding. For example, Elaine's health condition meant that she was advised not to breastfeed because to do so would have passed toxicity on to her baby. While she and her partner accepted this, she discovered that others did not:

'... I felt quite isolated, [...] there was 40 of us in our class, it was a big, big group. And I was the only one [who wasn't planning to breastfeed], and I really felt the other mummies were looking at me. They probably weren't, but I, and I said to the midwife after 'Look it's not that I don't want to, I can't!' And she said to me 'When the baby's born, some people give you advice then [about feeding with formula]' she said, 'but we can't tell you now, because we have to be seen to promote breastfeeding.' And I felt, and then, just silly things like, when we went to go to Boots [pharmacy], and we were buying [formula], you can't redeem [loyalty reward] points or anything against it. Because they promote breastfeeding'.

(British, middle class, part-time employment).

Elaine found it difficult to accept the perception of negative reactions from other mothers, midwives and even from the pharmacy. By explaining that feeding her baby infant formula wasn't a choice but a necessity, she sought reassurance from the ante-natal midwife that she wasn't falling behind the standards expected of prospective mothers. This was not forthcoming, and she was left feeling the unexpected isolation of social disapproval for planning to feed her baby infant formula under any circumstances.

Rachel became very distressed when she realised that her health visitor judged that her early mothering wasn't going well:

'I injured my nipple. You know, it was extremely painful, very, very, very sore. And, I seen the health visitor [...] once so, maybe with the advice from my mum and my friends, I stopped breastfeeding and [...] expressed, three times a day and, gave her formula the rest of the time. So [...] the health visitor came back [...] ten days later. And, there's no other words to describe it, she wasn't happy. [...] I was left in tears. That was really the first time that I really cried, you know I thought that we were getting on well, and I was left to feel that, we weren't.'

(British, upper middle class professional, full-time employment).

The distress Rachel recalls damaged her sense of herself as a competent mother, a shame response which is likely to cause withdrawal and isolation (Barbalet, 2001). Rachel did not return to breastfeeding after this, despite the continued insistence and disapproval of the health visitor involved, whispering that 'I got through it'.

Jennifer recalled the disapproval she experienced when she introduced a bottle of infant formula at night to her breastfed baby. She did this on the advice of a midwife who said that her baby would be more satisfied and content if she received a bottle of infant formula at night, and that their relationship could then improve:

'I went back to the breastfeeding support group the week after [introducing the bottle], another midwife [was there]. I [...] told her I was doing this. [She] was obviously appalled and horrified that I stuck a bottle of formula in, as if I was giving the baby whiskey or something, you know, or like, knockout drops! So, it kind of made it, feel, you know, I felt really guilty. And in a way, like I remember saying to one of my friends, who was also a breastfeeding mum, who had terrible trouble, 'It's almost easier to, from the beginning say 'I'm not going to do it'. Because then you don't get, kind of, you don't get that guilt trip whenever you talk about introducing one bottle. And I did like eight weeks exclusive, which was hard going 'cause Sarah fed, constantly. [...] It's 'why are you stopping?' not 'Well done, you did eight weeks, you had mastitis, you were exhausted, that was really tough. Sleepless nights, all the rest of it. It's like, 'You should really continue, persevere, you should not give them formula', as if you're giving them something awful [laugh]'

(British middle-class, part-time employment).

Taylor and Wallace argue that when women refer to their feelings of guilt about breastfeeding, their emotional reactions are better described as shame, since they involve the feeling that they are not good mothers rather than that they have caused harm (Taylor and Wallace, 2012a). Jennifer's reflections seem to fit with this, since she didn't accept that feeding her baby infant formula was the equivalent of giving her baby whiskey. She introduced infant formula on the advice of a midwife, so didn't feel that she had caused harm to her baby. However, she did feel that the quality of her mothering was discredited in the breastfeeding support group, despite the effort she had gone to in persevering in the face of physical pain and sleep deprivation, and she was shocked that any modification in her feeding method would be enough to lose her hard-won early status as a good mother. Her response reflects her effort to protect herself from potential shame by withdrawing from those contexts where it may be experienced; that it would have been better never to have exposed herself to such harsh judgement by not trying to breastfeed at all.

Women who were determined to breastfeed but found themselves unable to could go to some extremes to give their babies 'the best' early care. Zara, for example, struggled for months to feed her baby with expressed breast milk since he didn't cooperate with breastfeeding:

'I was so determined to breastfeed. You know I really wanted it, and when he was born, I had no milk. [...] He was a bit jaundiced and, we just had to give him a bottle because he was hungry. I had no milk. And then, once you do that, [there's no going back]. I really thought I could, you know, whenever we come back, you know, [to our] home environment, it will be easier to happen. We really really tried for weeks. And, no, he would just cry every time he was put on the breast. He just wouldn't take it, so. I was very very disappointed. There was midwives that come out to the house, you know every day, they were all coming and, every day we were trying, different positions and, you know. So I was very very disappointed 'cause you want the best for them, and breastmilk is the best but. I couldn't. I started, pumping. And then, then it made everything, more, harder, because you're pumping and you are feeding so it's like doubling the work. So it was very very stressful because I had to get up every morning earlier than he did. Come down, pump for half an hour and

then he woke up, and then, you know, it was just very stressful. And all day, because he was such a handful, I was stressing about not being able to pump and [...] [worried that] my milk will dry up and, you know. And then once he went down [to sleep], I had to pump again in the evening [...], it was very very, you know, stressful and, I was doing it for three months.

I remember I went to a baby massage [class] with him and, everyone was breastfeeding and, and no-one had the dummy and, everyone's baby was happy and, I just felt like such a failure, you know?'

(Eastern European, middle-class, full-time employment).

A woman's feelings of shame at not being the mother she had hoped to become could be overwhelming. Ciara, a health care professional, broke down recalling her feelings about not being able to breastfeed her infant son:

'I wanted to breastfeed, and couldn't. It was just, he didn't latch on properly, but I kept insisting and insisting. I wanted to give this a go, and he was crying. There was one day, [...] he was on my breast for 23 hours. And he was trying to feed. He was trying and trying. And he just wasn't getting enough. So then, we did start bottle feeding. After about three weeks, I kept going and kept going for about three weeks, but every time I was putting him on I was in agony. So I kept thinking, I'm not doing this right, I'm a terrible mother.

(Irish, lower middle-class, part-time employment).

This sense of shame was difficult to cope with, and Ciara commented that she felt she needed counselling to come to terms with not breastfeeding. A lone parent, her self-isolation reflected her deep sense of shame:

'I think I just sort of wanted to cocoon myself with him, and just have everybody, like, go away, either pre-empt what I need and do it for me directly or just don't bother even coming at all because, you know, I just can't handle it.'

This illustrates Lynd's argument that, 'the experience of shame is itself isolating, alienating, incommunicable' (1958:67). Ciara's sense of herself as a good mother improved however as she watched her son thrive following the introduction of infant formula, as well as the reassurance she received from her own mother throughout this time.

<2>Conclusion

Infant feeding is often experienced as emotionally intense not only because of practical concerns with how one's baby might be growing and thriving, but also because of the moralised approach to promotion strategies. When breastfeeding is established as the hallmark of good mothering, the feeling that one is failing can be very damaging, whether one is not breastfeeding at all, or not breastfeeding appropriately or not breastfeeding with sufficient dedication. It should be no surprise that advertising for infant formula explicitly reassures non-breastfeeding mothers that this approach to feeding also signals devotion to infant health, bonding and taking pride in children's development (Aptamil, 2016).

Taylor and Wallace argue that the shaming effects of current breastfeeding advocacy also undermine attempts to normalise the practice, as avoiding potential shame can mean avoiding breastfeeding completely (Taylor and Wallace, 2012b). Louise, an upper-middle class full-time mother, recalled that during her second pregnancy, 'I just said [to midwives], "right guys, just don't even talk to me about it. I'm not doing it".' It should be no surprise that those much lower down on the social gradient than Louise are most reluctant to risk their feelings about themselves as good, esteem-worthy mothers, and avoid breastfeeding completely.

The question of how best to facilitate breastfeeding without threatening new mothers' fragile self-evaluations and status is an urgent one for health policy. Rather than simple slogans and solutions, a more nuanced, less moralised approach is necessary. This should focus on the structures within which early mothering takes place not on individual women and their partners.

<2>Notes

1. I am grateful to participants in the ESRC seminar series, *Social Experiences of Breastfeeding*, for feedback on the ideas contained in this chapter. I am also indebted to Cillian McBride, especially for discussion of esteem recognition and reassurance seeking.
2. All names have been changed to protect participant identities.

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