Contextualising risk, constructing choice: Breastfeeding and good mothering in risk society

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The ‘whats’ and ‘hows’ of feeding babies is a key interest in the arena of public health. In recent years, this has translated into an ever-increasing emphasis on breastfeeding; namely, on trying to get more mothers to breastfeed, to breastfeed exclusively, and to breastfeed for longer. It is argued, however, that this discourse is not a benign communique about the relative benefits of breastfeeding, but an ideologically infused, moral discourse about what it means to be a ‘good mother’ in an advanced capitalist society. With the dual aim of (a) building upon existing cultural analyses of infant feeding, and (b) furthering our understanding of the construction of ‘good mothering’ in risk society, this paper examines how notions of risk/benefit are taken up and used in mothers’ talk about their infant feeding decisions and experiences. The findings detailed in this paper support the thesis that the authority to define and monitor ‘risk’ in parenting is increasingly the purview of medical-scientific discourse. The analysis further demonstrates how, within such a framework, mothers’ risk consciousness vis-a-vis infant feeding is activated primarily as an issue of identity, of ‘good mothering’ as defined by the dominant, expert-guided, scientific-medical discourse.

Keywords: parenting; risk; risk communication; risk perception; public health; uncertainty; breastfeeding

Introduction

Risk consciousness is a central feature of modern life. As one of the primary concerns of modern post-industrial societies, we are becoming increasingly concerned with understanding, calculating, communicating, managing, and otherwise minimising or eliminating myriad risks associated with everyday life (Beck 1992, Slovic 2000). So it is for the arena of parenting and motherhood. Indeed, it is argued that the role of motherhood in contemporary society is being redesigned in such a way that mothers are being increasingly positioned as veritable ‘risk managers’ (Furedi 2002, Reese 2005, Lee 2008).

Within this ideology, mothers are seen as having a moral and social responsibility to be risk conscious. They are also seen as being in need of professional guidance in order to risk-manage effectively:

in risk society . . . the parent is construed as unable to risk-manage effectively without professional ‘support.’ Cultural norms . . . thus construct the ‘good/responsible mother’

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as the mother who is alert to the manifold risks posed to her child(ren) by contemporary society, and considers it her job to manage these risks through reference to expert opinion. (Lee 2008, p. 469)

In other words, expert-guidance (typically scientific-medical in nature) is required for mothers to be able to: (a) properly identify what is or is not considered a risk worthy of managing/eliminating; and (b) properly learn how to minimise or eliminate those risks.

Risk, however, is socially and ideologically mediated. For example, the social amplification and attenuation of risk model shows how social institutions play an important role in shaping constructions of risk, as well as how recipients of risk messages also engage in amplification and/or attenuation processes (Kasperson and Kasperson 1996, 2005). Indeed, ‘risk consciousness’ and associated decision-making is often related more to the emotive consequences and meanings attached to certain identified risks than to any rational calculation of probability (Kasperson and Kasperson 2005; see also Alaszewski 2005, Thirlaway and Heggs 2005). In order to further develop this theoretical perspective with respect to contemporary parenting culture, it is important to explore the meaning of risk in different mothering contexts, and to examine how mothers come to conceptualise what ‘counts’ as a risk or benefit for their children in different mothering situations. The current analysis asks these questions specifically with respect to infant feeding.

Background and method

The ‘whats’ and ‘hows’ of feeding babies has long been of interest to medical and health professionals (Apple 1987, Blum 1999, Wolf 2001, Murphy 2004). In recent years, this has meant efforts aimed at getting more mothers to breastfeed, to breastfeed exclusively, and to breastfeed for longer (Dennis 2003, Health Canada 2004). Towards this end, today’s dominant infant feeding discourse strongly purports the importance of breastfeeding for babies’ (and to a lesser extent, mothers’) health and wellbeing. Promoting a return to ‘breastfeeding as the cultural and biological norm’ (Alberta Breastfeeding Committee 2009) can be viewed as inherently positive for increasing the protection of breastfeeding as a basic reproductive right, for improving access to lactation specialists/breastfeeding support for new mothers, and for contributing to increased rates of breastfeeding1 (Wright 2001, Van Esterik 2002, Millar and Maclean 2005). However, there is also a growing body of literature highlighting some of the more problematic aspects of contemporary pro-breastfeeding discourse.

For one, researchers have illuminated how today’s dominant infant feeding discourse functions more as a vehicle of persuasion than as a vehicle of education, characterised by informational biases, moral overtones, and a restrictive construction of choice (Law 2000, Wall 2001, Murphy 2004, Knaak 2005, 2006, 2009a, Kukla 2006, Avashai 2007, Wolf 2007, Lee and Bristow 2009). Attention has also been given to the increasingly hegemonic and homogeneous character of pro-breastfeeding discourse, where alternative choices about infant feeding tend to be interpreted as acts of moral deviance rather than counter-discourses or acts of resistance (Murphy 1999, 2000, Lee 2008, Lee and Bristow 2009).

While pro-breastfeeding discourse is clearly a medical-based discourse in that it emphasises the nutritional and health risks and/or benefits of various infant food sources, it is also one which positions breastfeeding as the proper and ‘moral’ choice.
Mothers are told that ‘if you don’t breastfeed your baby, you’re automatically out of the running for Mother of the Year’ (Douglas 2001, p. 244). In this respect, breastfeeding discourse is strongly hooked into broader ideologies of what it means to be a ‘good’ mother in today’s society (Schmied and Lupton 2001, Schmied et al. 2001, Wall 2001, Knaak 2009a). The expert-guided nature of today’s dominant parenting ideology (Hays 1996) is part of what lends power to this feature of contemporary breastfeeding discourse. Because ‘good’ parenting is defined as that which is informed/guided by experts, mothers are bound to an ideological framework whereby health professionals, not mothers, are deemed the primary experts of child rearing (Hays 1996, Grant 1998, Wallace and Chason 2007).

The increasing moralisation of public health is another part of what lends power to this feature of contemporary breastfeeding discourse. Namely, the tendency in public health discourse to increasingly frame personal health choices/practices as issues of social and moral responsibility (Lupton 1993, Petersen and Lupton 2000) makes breastfeeding much more than just a personal decision. Within this kind of discursive environment, breastfeeding becomes part of how good (i.e. socially responsible, moral) motherhood is defined.

The current study builds on this body of research by exploring how notions of risk are activated and deployed in the context of infant feeding. More specifically, the interest for this paper is to understand how mothers think about risk in making infant feeding choices and decisions. In so doing, the analysis draws on data from qualitative interviews conducted with 33 Canadian mothers about their infant feeding experiences.

The original study for which these interviews were conducted was broader in focus, encompassing a breadth of postnatal experiences, issues, and decisions. However, in my conversations with mothers about their experiences in the weeks and months after having a baby, infant feeding emerged as a key part of their postpartum experience. Thus, for the purposes of this paper, I extracted and analyzed the interview components related to mothers’ thoughts, decisions, and experiences with infant feeding.

The final interview sample for this analysis included mothers of varying ages (from 20 to 36 at the time their first child was born), income levels (ranging from dependence on social assistance to a household income of over C$100,000 per year), and education levels (from uncompleted high school to doctoral candidates). The mothers ranged in parity from one child to four. All mothers, with the exception of one, were of Euro-Canadian origin. Participants were interviewed anywhere from three months postpartum to five years after the birth of their last child. At the time of the interview, all mothers resided in and around the city of Edmonton, in the province of Alberta, Canada. In keeping with Research Ethics Board requirements, all interview excerpts included in this paper rely on the use of participant pseudonyms.

Findings

Risk consciousness and the conditioning of choice

Of the 33 mothers I interviewed, breastfeeding was undertaken by all but one mother. Thus, with the exception of Penny, who had decided from the outset against breastfeeding, the mothers in this study were committed to the idea of breastfeeding. And while they acknowledged that a choice did exist, at least formally, with respect to the ‘hows’ and ‘whats’ of feeding babies (they acknowledged that breastfeeding,
formula feeding, and combination feeding were all considered ‘possible’ choices), most of the mothers never considered any option other than that of breastfeeding:

[Breastfeeding] wasn’t ever something I questioned (Fran).

I always knew I was going to breastfeed my kids . . . there was no question that I wouldn’t (Sally).

For these mothers, the notion of choice existed mainly as a discursive formality, not as a personal reality:

I don’t think negatively of people who make that choice [to formula-feed]. I think that’s an individual choice, you know. I mean, I think breast milk is better than formula. So for them, that’s fine. But for me, I . . . had decided I was going to do the breastfeeding no matter what . . . You know, I don’t look down on people who don’t. I think it’s fine, you know. But I had to do it. No question (Suzanne).

Importantly, these 32 mothers breastfed because they wanted to, because it was ‘very very important’ (Alice) to them. And, even though they identified a strong ‘culture of pressure’ (see section Reinforcing and challenging dominant conceptions at risk: Pressure and resistance, p. 6) in favour of breastfeeding, the mothers in this study did not feel coerced or forced to breastfeed. With few exceptions, these mothers spoke about their decision to breastfeed with considerable intensity and conviction. It was, as Alice stated, ‘a big big belief’ for them.

The intensity with which mothers spoke about infant feeding begs the question of why breastfeeding was seen by these mothers as so important. Although breast milk is known to be healthier than formula, a broader contextualisation of risk reveals that the magnitude of these health/nutritional differences is relatively small, particularly when compared to the risk of feeding babies something other than either formula or breast milk (Knaak 2006). And, even though maternal care in Canadian health contexts clearly promotes breastfeeding as the ‘recommended choice,’ it does still endorse formula as the accepted alternative. As the Calgary Health Region’s From Here Through Maternity (2008, p. 171) document states, for example:

if you decide to give your baby something other than breast milk, commercial iron-fortified infant formula is the recommended choice.

This broader contextualisation of risk, however, was not a main feature of mothers’ infant feeding ‘risk consciousness.’ Rather, the mothers in this study tended to see breastfeeding and formula feeding as monumentally different in terms of the risks and benefits associated with each:

I’ve heard all these things about how horrible [formula] is, and you know, I always said, ‘I’m only going to nurse’ . . . and my husband was trying to convince me, saying ‘well, maybe we could give him some formula, it would give you a break.’ You know. But no way in hell was I going to do that. I’m going, ‘you’re not going to introduce that stuff to my baby’! (Gabrielle, emphasis hers)

I wanted to commit myself to . . . be a good parent. To me breastfeeding was part of that. (Fran)

[Breastfeeding] offers much better protection . . . against diabetes. So, that pretty well was the only consideration after that was mentioned . . . You know, as soon as that was explained to me there was no question that I wouldn’t. (Sally)

I have, I guess, a lot of strong beliefs that I didn’t—oh, I kind of knew I had—but I didn’t really realise how they impact me on how to raise a kid and what I believe is best
for raising kids . . . feeling like, what happens if I have to give my baby formula? Well, I
don’t believe in that . . . I’m so glad that we worked through everything. If he refused
the breast I would—that would be horrible. (Alice, emphasis hers)

There are a few observations to be drawn from these mothers’ accounts. For one, as
illustrated in Gabrielle’s comment, many of the mothers viewed commercial infant
formula not only as nutritionally less superior, but in specifically negative terms.3 In
as much as the larger discourse acknowledges both breastfeeding and formula
feeding as ‘acceptable’ choices, there is an ever-increasing discursive gap between
these two options; namely, that breastfeeding has become more and more idealised,
and formula feeding ever more devalued (Knaak 2005). These findings suggest this
trend is playing a notable role in conditioning mothers’ infant feeding beliefs and
decisions.

Secondly, while these mothers were very much accepting of the discursive
emphasis on the health/nutritional benefits of breastfeeding (as indicated by Sally’s
comment, for example), Fran’s and Alice’s comments suggest that breastfeeding
represents much more than sound nutritional practice. Indeed, for many of the
mothers in this study, breastfeeding emerged as a key marker (to self and others)
about who they were as mothers, about how they mothered, and about what they
stood for.

Breastfeeding was identified as a ‘core mothering belief,’ a cornerstone of their
broader philosophy of (good) mothering, and part of the foundation of their ‘picture
of self’ (Mercer 1995, p. 118; see also Knaak 2009b) as mothers. Breastfeeding
represented a key marker that they were committed to ‘doing everything right and
not making any mistakes’ (Emily), to ‘mak(ing) the most of what [they] could offer as
a mom’ (Fran), and to ‘doing what’s best for the baby’ (Astrid).

By contrast, the decision to not breastfeed represented something rather non-
understandable (Fatima) and even ‘horrible’ (Beth) to many of the mothers in this
study. It was inconsistent with the tenets of good mothering, of ‘doing what’s best’:

a friend of mine who works fulltime, she chose not to breastfeed, and I thought, ‘oh
she’s horrible, how could she not do that?’ . . . For me personally, it wouldn’t ever occur
to me that I wouldn’t try to breastfeed. (Beth)

I do know that sometimes you can’t [breastfeed] for various reasons . . . But I don’t
know, I guess I can’t—I don’t understand that, to choose not even trying to, you know.
(Fatima, emphasis hers)

As noted above, this association of breastfeeding with ‘good mothering’ and formula
feeding with ‘not so good mothering’ has been argued to be a key characteristic of
today’s dominant infant feeding discourse. In large part, this can be attributed to the
fact that pro-breastfeeding discourse is organised and mediated by: (a) a moralising
public health ideology (Petersen and Lupton 2000); and (b) the ‘ideology of intensive
mothering’ (Hays 1996, Wall 2001, Knaak 2009a), today’s dominant parenting
ideology.4 Again, these findings suggest that mothers’ infant feeding beliefs and
decisions are being heavily conditioned by these broader discourses.

The risk of failure

It is in this context that the theme of perseverance emerged as central, particularly
among mothers who experienced difficulties with breastfeeding, such as nipple and
breast pain, mastitis and other infections, latch problems, etc. As Suzanne’s
comment illustrates, mothers invested an extraordinary amount of physical and emotional energy into ensuring they were successful with breastfeeding:

I had decided I was going to do the breastfeeding no matter what. So, yeah, I was very stubborn about that. I don’t care how much it hurts or anything . . . for me, I felt like I have to do this naturally. I have to. And I don’t know, I just—in my head I thought I’ll wait for six or eight weeks but I knew even if that time came and went, I’d probably give it another two weeks. And another two weeks. And I would keep doing it. I just thought, I have to . . . I had to do it. (Suzanne, emphasis hers)

What became clear from my conversations with these mothers was that success with breastfeeding mattered. However, breastfeeding mattered not only because it represented the epidemiologically healthiest choice for infant feeding, but because breastfeeding is what good mothers do. For these mothers, success with breastfeeding was primarily an issue of identity:

it got to that point where I could not imagine not being successful with [breastfeeding] And, I just thought, I can’t even go there with it, because it truly, I think, would have totally spiralled me into a serious probably state of depression . . . it just seemed to me that it would have been a really strong sense of failure, and failure as a mom and so I just, I couldn’t feel this. (Natasha, emphasis hers)

Thus, for most of the mothers in this study, perseverance (and success) with breastfeeding was an indication of their commitment to good mothering; to making choices about ‘what’s best,’ as defined by the dominant discourse.

In this context, the mothers who managed to establish a breastfeeding practice they were comfortable with often described how breastfeeding became a ‘source of pride’ for them (Mary, for example), and/or was an ‘empowering’ experience (Jill, for example). For these mothers, getting breastfeeding established signalled a moment of accomplishment, a marker of their own mothering capability. By contrast, the two mothers in the study who held breastfeeding as a ‘core mothering belief’ and were not able to establish a comfortable or satisfactory breastfeeding practice spoke of how this led to feelings of failure and inadequacy as a mother:

I had several problems with breast feeding . . . so eventually I just gave up and bottle fed. But I struggled for three months I think . . . I felt so horrible about myself that I couldn’t do this for my child. I don’t know. Even though I was doing everything I could, I mean, everything. I just could not. It just wouldn’t happen for us, you know? It was so, I don’t know. You feel like less of a person, less of a mother, less of a woman even, you know, that you can’t do this for your child. (Beth, emphasis hers)

Thus, for the vast majority of the mothers interviewed, breastfeeding was an internalised ‘core belief’ of what it meant to be a good mother. In this sense, breastfeeding failure (whether as prospect or reality) was the key, overriding risk these mothers worried about. They worried about this risk because they felt strongly that their child would be unhealthy if fed formula, but because it would threaten their status and identities as good mothers. Risk consciousness was, first and foremost, a risk of identity.

Reinforcing and challenging dominant conceptions of risk: Pressure and resistance

Many of the mothers in this study talked about the existence of a ‘culture of pressure’ regarding breastfeeding. Thus, even though most of them held
breastfeeding as a core belief, these mothers also acknowledged that the emphasis currently placed on breastfeeding (and the associated negative interpretation of formula feeding) was continually being reinforced in the broader culture. Literature produced by, and interactions with, the health community was one avenue where mothers felt this pressure. Many mothers also talked about this ‘culture of pressure’ as reaching far beyond the health community, into the fabric of everyday parenting culture:

believe it or not, the people who did give me some harsh things about [my decision to not breastfeed] were men. Like my boss and the guys at work. You know, who were fathers. ‘You should breastfeeding.’ And I’m thinking, why does a guy have the right to tell me that I have to breastfeed? (Penny)

Many mothers described how the pressure they felt was just ‘there,’ existing as a kind of cultural peer pressure:

I can see [breastfeeding] being a real issue I think for a lot of women. Because there is some—I don’t know if it’s real outwardly pressure or if it’s just more subtleties. (Natasha)

What then, about the possibility of resistance? As mentioned earlier, one of the mothers in this study (Penny) decided against breastfeeding, citing strong personal aversion as the main reason behind her decision. And while Penny did experience both pressure and guilt with respect to her choice, she nevertheless felt strongly that formula feeding was the best decision for her. As indicated in the following excerpt, the process of Penny’s ‘identity work’ (Murphy 1999, 2000; see also Lee 2008) involved (re)positioning herself (not the dominant discourse) as the expert regarding how best to care for her baby:

I never felt comfortable breastfeeding, but when I got pregnant you get the pressure from everybody around you to breastfeed ... and I started to debate it, and I started to think, ‘well, maybe I should,’ and then I thought, ‘no, I still don’t feel comfortable out this’ ... but you still feel guilty if you don’t breastfeed at first. You think that you are not giving them something that they should be getting. And you want to be such a good mom. But then, now, I’m like, ‘oh, come on, you know. The stuff they do with formula nowadays. Give me a break.’ She’s just a normal healthy kid, gaining weight, healthy and everything ... A lot of moms follow the book to the ‘T’ you know, of how to do things ... I do think it frustrates me more to see moms following too much of the book, I guess ... I mean, I do read the books a lot, you know, but then I sort of say ‘okay, how much of that do I really take, you know’. (Penny)

The extent to which Penny eventually came to feel confident and self-assured about her decision to not breastfeed, the extent to which she directly challenged the need to ‘follow the book to the “T”’ and the extent to which she saw that her baby was a ‘normal healthy kid’ despite being formula fed, all point to potential avenues for resistance to the dominant (expert-guided) discourse. However, the fact that Penny was the only mother of the 33 I interviewed who took this position, coupled with the fact that she still described feeling guilty for not breastfeeding, suggests that such counter discourses enjoy a rather muted and questionable discursive legitimacy.

Conclusions
As discussed above, one of the foundations of today’s dominant parenting culture is one of ‘expert-guidance,’ whereby various medical, psychological, and other
professionals (not mothers) are deemed the primary experts of contemporary child rearing (Hays 1996). More than ever before, ‘good’ parenting is non-contextual and non-experiential. It is increasingly standardised and medicalised. Within this ideological context, the authority to define and monitor ‘risk’ in parenting is increasingly becoming the purview of medical-scientific discourse.

The mothers in this study were no exception to the current ideal of expert-guided parenting. They easily activated, typically with little or no resistance, the dominant medical-scientific discourse on infant feeding; a discourse which positions breastfeeding vis-à-vis formula feeding largely in terms of a ‘breastfeeding = benefit = good mother’ vs. ‘formula feeding = risk = bad mother’ binary. (This, despite the fact that both substances are both formally recognised as ‘acceptable’ choices.) Indeed, for nearly all of the mothers in this study, their commitment to, and perseverance with, breastfeeding was an indication of their commitment to making choices about ‘what’s best,’ as established and defined by the dominant scientific-medical discourse.

Thus, as suggested by this analysis, the risk consciousness which conditions the choices and decisions of ‘good’ mothers is not one where risk is situationally-contextualised, nor is it one that understands infant feeding decisions as being about how to ‘balance(e) the labors, pleasures, well-being, development, and opportunities of a household’s various members’ (Law 2000, p. 422). Rather, the risk consciousness which conditions the choices and decisions of ‘good’ mothers is the risk framework constructed by broader agents and institutions of contemporary parenting culture (such as health ministries and ‘expert’ baby care manuals, for example), agents, and institutions which are, themselves, organised/mediated by broader ideological frameworks (such as the ideology of intensive mothering and contemporary public health ideology, for example).

As mentioned above, understanding how people make sense of risk, and how this influences and otherwise intersects with their decision-making processes, is an active and important area of social research (Slovic 2000, Alaszewski 2005, Kasper and Kasper 2005, McComas 2006). We know that individuals’ responses to risk messages are powerfully influenced by the ‘extent to which they trust the source’ (Alaszewski 2005, p. 104, McComas 2006) from which they are receiving their information. We also know that individual’s risk consciousness often has less to do with objectively evaluating the likelihood and severity of particular risks, and more to do with the emotive consequences and meanings attached to certain identified risks (Kasper and Kasper 2005).

As also noted above, the social amplification and attenuation of risk model emphasises the important role played by social institutions in shaping constructions of risk:

since most of society learns about . . . risks and risk events through information systems rather than through direct personal experience, risk communicators . . . are major agents, or what we term social stations, of risk amplification or attenuation . . . the channels of communication are also important. (Kasper and Kasper 1996, p. 97)

This perspective also argues that recipients of risk messages engage in amplification and/or attenuation processes, such as decoding, processing, and attaching social values to the information received (Kasper and Kasper 2005).

The findings from this study suggest the applicability of the social amplification of risk framework for understanding how mothers activate certain particular
constructions of what ‘counts’ as a risk or benefit when talking about their infant feeding beliefs and decisions. This model’s emphasis on how various social stations are active agents in the construction and framing of risk is particularly useful, especially given that the ‘identity-based’ risk consciousness expressed by the mothers in his study reflected their internalisation of the broader, expert-guided discourse. As such, social amplification and attenuation of risk model is a useful framework to help understand how and why risk in infant feeding has become contextualised and taken up in the particular way that it has; not only in the dominant discourse but also by mothers themselves. Furthermore, given the ‘expert-guided’ nature of contemporary parenting culture more generally, it is also likely that this framework could prove useful for other issues relating to the construction and perception of risk in contemporary parenting culture.

Notes

1. Without question, these efforts have resulted in changing behaviours towards breastfeeding. Data from Canada, for example, show that 85% of mothers in 2003 initiated breastfeeding, compared to only 62% in 1980s, and 75% in the 1990s (Millar and Maclean 2005). Nearly half (47%) of mothers breastfed for six months or more, and approximately 18% are currently meeting the WHO target of exclusive breastfeeding for the first six months of a child’s life (Millar and Maclean 2005).

2. It is worth noting that the breastfeeding rate for the province of Alberta is, at 88% (1999 data), the second highest of all Canadian provinces (Health Canada 2003).

3. And while not all mothers held such strong views about formula as ‘bad,’ there was a common theme of feeling guilty or hesitant when it came to formula feeding, even when formula was being used temporarily, or as a backup/supplement to breastfeeding. The exception to this was when formula was introduced later on, in line with the introduction of other solid foods.

4. According to Hays (1996), contemporary definitions of ‘good parenting’ rely on the following main tenets: (a) the belief that mothers should be self-sacrificing and selfless; (b) the belief that rearing should be done primarily by individual mothers; and (c) the belief that it should be entirely centered on children’s needs with ‘methods that are informed by experts, labour-intensive, and costly’ (Hays 1996, p. 21).

5. For most mothers, this meant maintaining (or returning to) a practice of exclusive breastfeeding. For a few mothers, this meant a practice involving formula supplementation and/or feeding expressed breast milk via bottle.

6. A number of mothers also noted that while the pressure to breastfeed did exist in the health care context, their specific interactions with health care professionals were positive, characterised by flexibility and understanding.

7. It is notable that the issue of severe bodily discomfort has all but disappeared from today’s dominant infant feeding discourse (Knaak 2005), despite the fact that many sexual abuse survivors have a particularly difficult time breastfeeding . . . (and) 43% of new mothers who are not breastfeeding describe it as ‘primitive,’ ‘ugly,’ or ‘unpleasant’ (Kukla 2006, p. 163).

References


