MONITORING MILK AND MOTHERHOOD: Lactation Consultants and the Dilemmas of Breastfeeding Advocacy

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Research devoted to the topic of breastfeeding in contemporary society has largely focused on maternal experiences, at the micro level, and on policy messages directed at mothers, at the macro level. This paper adds to the literature by analyzing a heretofore understudied meso-level link in the breastfeeding process: the work of lactation consultants. Using data from in-depth interviews with International Board Certified Lactation Consultants, I examine how they characterize their role in shaping early motherhood. Findings reveal that by highlighting the realities and subjectivities of individual women and by emphasizing maternal empowerment and choice, professional lactation consultants aim to realize women’s individual goals. In their practice of monitoring early motherhood, lactation consultants often resist the normative breastfeeding ideology and thereby interrupt broader policy projects that aim to foster wholesale change in maternal infant feeding practices.

Women are routinely subjected to medical scrutiny of their reproductive behaviors. Maternal bodies, especially, fall within a web of expert surveillance and monitoring in order to optimize fetal and infant health outcomes. This starts in pregnancy when potential mothers are monitored, socially and medically, to assess risks to fetal health (Armstrong, 2003; Kukla, 2005; Lupton, 1999a; Lupton, 1999b; Lyerly et al., 2009; Rothman, 1993) and continues after childbirth (Wolf, 2007a). Infant feeding discourse, in general, represents a particularly good example of this post-natal messaging; and breastfeeding, in particular, comprises part of the contemporary construction of “moral motherhood” (Lee, 2007).

Indeed, breastfeeding is currently a hot-button cultural issue that sparks fervent commentary about the regulation of maternal behavior, often with morality-infused dialogue. For example, a recent article in the New York Times ended with a quote, “for God’s sake, please breast-feed,” from a medical researcher imploring women to give their infants the benefits of breastmilk.
Controversy also recently surrounded a supermodel who claimed that a universal law should be in place to require women to breastfeed for six months (Nathan, 2010), and Facebook was met with protests after it censored photos of breastfeeding mothers on its website (Belkin, 2008). In the past year, cultural commentators have showcased the cultural significance of bottling breastmilk (Lepore, 2009), proffered arguments against breastfeeding (Rosin, 2009), and conceded that breast-pumping is a “grotesque” act (Warner, 2009). At the same time, media reports have highlighted studies that tout the ability of breastfeeding to burn extra calories (Louis, 2009) and save the nation billions of dollars (Bartick and Reinhold, 2010). The Centers for Disease Control and Prevention (2008) recently called for coordination of lactation care and changes in hospitals and birth centers to facilitate breastfeeding, and the health care reform act of 2010 even acknowledged the need to formally protect women workers who breastfeed (Congress, 2010).

These debates are not new. Nation-states and publics have long been interested in promoting and monitoring breastfeeding (Kukla, 2006). In the early twentieth century, groups like the Boston Committee on Milk and Baby Hygiene were established to monitor mothers of both breast-fed and bottle-fed infants (Apple, 2006). Women were encouraged to seek expert medical advice in order to raise their children healthfully (Apple, 1995), adding to the surveillance and medicalization of motherhood over the course of the twentieth century (Litt, 2000). Counter movements rejected bottle feeding and the scientific establishment, and La Leche League (LLL) organized to push U.S. culture toward breastfeeding accommodation (Apple, 2006; Bobel, 2002). Since the 1950s, La Leche League, has been in the service of adjudicating “bad” from “good” mothering by equating “good motherhood” with breastfeeding (Weiner, 1994). And, while it moved infant feeding support out of the hospital and into a culture of women helping women, researchers argue that LLL’s strategy produced the paradoxical effect of both empowering and restricting women’s lives (Blum, 1999; Blum and Vandewater, 1993; Bobel, 2001; Rothman, 2007; Weiner, 1994). While popular, LLL did not have a formal position in the medical or scientific arena of infant feeding. By the late twentieth century, breastfeeding was found to be a medically superior practice, and the dominant medical model of breastfeeding required external regulation of the mother (Blum, 1999: 65). Breastfeeding has now fallen under a layer of contemporary expert surveillance with the rise of lactation consulting (Avishai, 2007), and we have since witnessed increased social and policy pressure on mother’s feeding decisions.

In its 1997 report, the American Academy of Pediatrics recommended that mothers breastfeed for one year. One critic called this policy position a
“sick joke” in a society with no paid maternity leave (Crittenden, 2001). Then, in 2000, the Department of Health and Human Services (DHHS) issued its “Blueprint for Action” on breastfeeding, detailing the goals for Healthy People 2010 and providing the base and impetus for the National Breastfeeding Awareness Campaign (NBAC) four years later. This constituted arguably the most visible contemporary policy push for changing maternal behavior with regard to breastfeeding. The campaign (2004-2006) slogan, “Babies Were Born to Be Breastfed,” graced billboards, while other advertisements exposed the risks of not breastfeeding, pointing to the potential of breastfeeding to reduce childhood ailments such as respiratory illness and obesity (Department of Health and Human Services, 2000). Risk discourse in contemporary public health tends to exploit notions of blame and guilt to perpetuate social control over health behaviors (Lupton, 1993), and critics of breastfeeding advocacy have pointed out that this new layer of regulatory advice has the potential to make mothers feel guilty about their infant feeding choices while ignoring the realities of women’s lives (Blum, 1999; Kukla, 2006; Law, 2000; Wall, 2001; Wolf, 2007a). While some studies have focused on the positive relationship between breastfeeding and maternal health (Baker et. al., 2008; Schwarz et. al., 2009), the public health message for breastfeeding generally exhibits a lack of concern for maternal subjectivity.

In her critique of the ethical license taken by the NBAC, Wolf develops the concept of “total motherhood,” which refers to the contemporary moral expectation that infant lives (and health) be optimized, even if this endeavor trumps the needs of the mother:

When mothers have wants, such as a sense of bodily, emotional, and psychological autonomy, but children have needs, such as an environment in which anything less than optimal is framed as perilous, good mothering is construed as behavior that reduces even minuscule or poorly understood risks to offspring, regardless of potential cost to the mother (Wolf, 2007a: 615, emphasis in original).

As Wolf notes, breastfeeding is a vital part of the total motherhood discourse (2007a: 617). However, competing with breastfeeding advocacy discourse is a body of social science research that highlights those times when it is not always ideal, or even possible, for a woman to breastfeed. The difficulties women face when breastfeeding range from physical pain (Kelleher, 2006) to occupational and cultural constraints (Galtry, 2000; Lindberg, 1996; Stearns, 1999) to feelings of inadequacy as mothers when they cannot breastfeed or do not enjoy breastfeeding (Lee, 2007; Lupton, 2000; Schmied and Lupton, 2001). A divide surely exists between policy messages and the realities of most women’s lives.
A NEW PROFESSION FOR AN OLD PRACTICE: THE RISE OF LACTATION CONSULTING

Lactation consulting services often attend to this disconnect between policy messages and reality, as they work to troubleshoot problems that new mothers face when confronting the decision of whether or not to breastfeed. Support and advice for new mothers has always existed, but never was this knowledge codified as separate from the work of midwives, nutritionists, RNs, and doctors. Although La Leche League International served an influential role in the beginning, the professional occupation of lactation consulting emerged as a credentialed alternative to La Leche League advice, which had always been a non-profit venture (Avishai, 2007). With the formation of a professional organization and a board certification test in the 1980s, lactation knowledge and services were standardized (Edwards, 1985). In the United States, to become an International Board Certified Lactation Consultant (IBCLC), a significant amount of lactation-specific clinical experience is required. According to the Centers for Disease Control and Prevention, based on 2007 birth data, there were 4.61 IBCLCs available per 1,000 live births in the state of Massachusetts, the site of this paper’s study (CDC, 2010). And the International Board of Lactation Consultant Examiners reports that there were 355 IBCLCs in Massachusetts as of 2009 (IBLCE, 2009). This occupation appears to be important in obtaining desired rates of breastfeeding (Bonuck et al., 2005; Castrucci et al., 2006). In addition, hospitals have made shifts in the past two decades by adding formal breastfeeding support, employing certified lactation consultants, and establishing specific departments within the hospital for “Lactation Services.”

Studies have examined the tensions new mothers face with health professionals when making breastfeeding decisions (Lee, 2007), how women’s interactions with their consultants can generate (or ease) anxieties among new mothers (Kelleher, 2006), and the importance of the care environment during the neonatal period for women’s decisions to breastfeed (Flacking et al., 2006). In her study of the breastfeeding “project” that class-privileged women undergo in contemporary society, Avishai (2007) examines the breastfeeding experiences of a group of white, college-educated, and white-collar professional women and details their relationship with their lactation consultant. Avishai asserts that “lactation consultants are a vital resource for some breastfeeding mothers” and that “these experts are better positioned to assist breastfeeding mothers than either pediatricians or obstetricians” (2007: 143-144).

This study extends the prior research by examining how lactation consultants, as those professionals trained to work directly with new mothers
on these matters, frame their relationship to the work of policing early motherhood. Do they promote the “total motherhood” ideology in their practice? In seeking answers to this question, this study fills an important gap in understanding the process and politics of breastfeeding in contemporary culture. It does the exploratory work of gauging what exactly lactation consultants have to say about their profession and new mothers within a context of heightened breastfeeding awareness, as they serve as mediators between women’s experiences and external political advocacy.

METHODS

To analyze how this relatively new profession relates to the politics of monitoring early motherhood, I conducted in-depth interviews with twenty International Board Certified Lactation Consultants (IBCLCs) in eastern Massachusetts during 2007-2009. The lactation consultants were recruited through a publicly-available list provided by the International Lactation Consultant Association (ILCA) and also minimally through snowball sampling. All participants were white women ranging in age from early thirties to mid-sixties. Two respondents became certified as IBCLCs without previously working in the health care field. The rest of the respondents were registered nurses (RNs), and the majority was comprised of specialized nurse practitioners. The interviews lasted between one and two hours each. The interview guide included questions about general breastfeeding advocacy, specific questions on DHHS breastfeeding public health campaign materials, and the practice of monitoring maternal infant feeding practices. Following the semi-structured interview, enough time was allotted for the participant to delve into issues and matters that were important to her, as related to her work with mothers and her work as a breastfeeding advocate. Many of the interviews took place in the hospital or clinic where the LC worked; others took place in either a local café or the participant’s home. All interviews were transcribed, and coding corresponded to responses to thematic questions, such as “what is your breastfeeding philosophy?”

FINDINGS

In explicating their thoughts on breastfeeding advocacy and new mothers, lactation consultants were unanimously, and expectedly, in favor of universal and exclusive breastfeeding. They all believed that breast milk is the optimal and superior form of nutrition for infants. Despite this wholehearted belief in breastfeeding, nuance emerged among the LCs’ narratives when they discussed their thoughts on breastfeeding advocacy and their work “on the
ground” with new mothers. For instance, one respondent explained that her own goals as a breastfeeding mother do not always coincide with her professional goals of supporting parents in a variety of situations:

My professional philosophy is that I think moms need a lot of support. First time parents need a lot of support in general. I think when it comes to breastfeeding there is not enough support out there. My goal is to help them meet their goals and I try to encourage them that every bit of breastmilk their baby gets is wonderful and just give lots of support. When they need to or they decide if things aren’t going well, that it’s time to move on, I like to try to support them with that. For my personal self, I have very high expectations.

Personally, this LC holds herself to a high standard of exclusive breastfeeding, but she understands that other women might have different goals. This was illustrative of the LCs in this study, all of whom believe that “breast is best” and that all mothers should breastfeed. Professionally, though, they concede that their work is more complicated than telling mothers to “just breastfeed” as policy messages do. Indeed, the respondents revealed that the pressure of the “just breastfeed” message is not realistic. One respondent explained: “Sometimes I’m conflicted because [there is] this one part of me that’s sometimes disappointed in that I’d love to just see everybody breastfeeding. You know, just breastfeed! At the same time, I always try to balance that with looking at that woman’s life.” The interviewees described how they mediate breastfeeding advocacy and regulation of maternal behavior by working with the realities of women’s lives and choices. Their work and their opinions point toward two major dilemmas that highlight and animate how the LCs function in their professional role of breastfeeding supporter.

Dilemma 1: Breastfeeding Advocacy and Individual Realities.

“My philosophy, let’s just say my philosophy about my job is that first and foremost I really try to support the mother and her goals. Overall, I think breastfeeding is the best thing; breast milk is the best nutrition. It’s obvious; I mean there’s no question. But, as a lactation consultant I do try to really promote mother-baby bonding and I really try to support the mother the best I can for her situation because it’s not always ideal.”

The first emergent dilemma in the respondents’ work concerns their professional focus. The breastfeeding rhetoric, they admitted, highlights the infant and benefits that accrue to the infant from breastfeeding. Women are often largely treated as instrumental, not central, actors in the larger discourse. In contrast, because LCs work directly with expectant mothers, new mothers, and the mother-baby dyad, they indicated that they often give just as much, if
not more, attention to the mother. The LCs revealed that it is through the maternal body and her subjective and embodied experience that breastfeeding occurs. Their breastfeeding recommendations were thus tempered by the realities of women’s lives. One respondent explained that, as a health professional, she simply has to worry about the mother’s well-being, despite her role in advocating breastfeeding:

I’m...very much a supporter of breastfeeding. I’m also fully aware of the realities of women’s lives these days. I’m happy...if we can get a mom to breastfeed partially, and then the baby’s getting some benefits...And if a woman, you know, strongly considers breastfeeding and then decides it’s not for her, for multiple reasons...then I try to provide support for the woman around that decision too. There have been times that my role as a women’s health nurse practitioner and the lactation consultant have sometimes not blended so well.

An understanding of all the different realities facing women, along with their own work as women’s health practitioners, pervades the LCs’ accounts of how they must negotiate their own occupational dilemma of advocating breastfeeding. As emergent from the respondents’ narratives, three types of obstacles to breastfeeding also became hurdles to breastfeeding advocacy: individual, structural, and cultural. In recognition of the challenges to breastfeeding in contemporary society, one LC stated that “it’s a wonder anyone nurses at all.”

First, in terms of individual obstacles to breastfeeding, respondents were particularly sensitive to the physical and psychological impediments that might factor into a woman’s decision to breastfeed. Examples of instances when respondents might discourage mothers from breastfeeding include maternal cases of HIV or AIDS, maternal history of breast surgery or C-sections, maternal use of assisted reproductive technologies, infant latching problems, maternal seizure disorders, maternal depression, infant metabolic disorders, breastmilk production problems, and maternal drug use. Several respondents noted that they had come to recognize that women who have been sexually abused, for instance, might not be comfortable with breastfeeding:

You know, I don’t have like a real hard stance that [breastfeeding is] black or white. I think every woman is different, you know they come to us with different experiences. Some women have had some experiences in their past that putting a baby to breast is very difficult for them or would be almost impossible for them. So you have to listen and you have to hear what they’re saying and go with it.

In these instances where psychological or physical factors counter-indicate breastfeeding, the LCs revealed that they have to recommend against...
breastfeeding. The respondents explained that these situations proved difficult for them because they want for every baby to have the opportunity to breastfeed. But, these instances also added to their complex understanding of how breastfeeding is not always an easy and universal behavior to promote.

The lactation consultants described other individual-level situations that might preclude breastfeeding, including life at home. The respondents were uniquely aware of the home dynamic of a new mother and her infant feeding habits. One respondent explained the pressures women might have in daily life: “Someone who has another three year old running around and trying to get things going with a new baby, it’s not always realistic...I like to look at the whole picture and how can I help this mother fit breastfeeding into her life and feel as [though] she’s satisfied with what she’s doing.” Most of the LCs mentioned encountering interpersonal situations that might impede breastfeeding, such as a partner’s or a family member’s lack of enthusiasm for breastfeeding. The respondents realize that the basic lack of time and energy that comes with having children and/or a dearth of support may present mothers with conditions that are not necessarily conducive to breastfeeding.

Structural factors, such as workplace organization, comprised the second emergent factor in understanding the obstacles facing women in terms of infant feeding decisions that in turn obstruct breastfeeding advocacy. One respondent explained the predicament posed by workplace culture:

[Breastfeeding is a] socioeconomic thing, because the more flexible jobs at the higher end...have offices with doors. If you’re a bank teller or on the assembly line somewhere, you can’t...it’s very hard to get access to any place besides the bathroom stall and you might not even be able to get out for 15 minutes to do that. Sometimes...it isn’t a bad thing to have formula in the kitchen in the shelf knowing that you might need it at the end of the week. I don’t think that’s a bad thing.

This was not an anomalous response. The LCs in this study frequently mentioned grabbing some formula for a mother or talking with a mother about bottle-feeding if they thought it might mitigate her situation. While all of the LCs expressed skepticism about the use of formula in general, they conceded that it has a useful purpose when it can alleviate maternal stress or when breastfeeding goes awry.

The respondents all thoughtfully articulated their view that broader structural forces shape the ability and willingness of women to breastfeed. In our discussions, the LCs promoted progressive policies that would more clearly recognize maternal subjectivities. For example, after discussing breastfeeding
awareness campaigns, one respondent expanded on the meaning of advocacy and structural change:

So I think it’s good information with the campaign but I think we have to reach women other ways also and I think unfortunately we’re not going to change the breastfeeding rates until we stop having formula companies monopolize hospitals, until we become more baby-friendly, until there is federal legislation that women can breastfeed in public and not get criticized for it, that workplaces have to support moms that are breastfeeding. I think there are just so many changes that need to happen.

Respondents also explained that cultural representations of breasts interact with structural obstacles to make it difficult for women to breastfeed anywhere outside the confines of the home. As they discussed this issue they illuminated a third kind of obstacle that women encounter when faced with infant feeding decisions. The respondents overwhelmingly mentioned how hard it is to breastfeed in a society in which breasts are so sexualized. One LC discussed her view of the perception of breasts in popular culture:

It is a strange, strange society and when it comes to breasts it’s the oddest thing. I can’t even get it straight in my mind. Like you could have Anna Nicole Smith and the Baywatch girls...their breasts are like glorified but if you use them to breastfeed your baby it’s like “Ooohh.”...I just think we have a warped sense of what the breasts are about and I think we have a highly sexualized society. Everything, everything is commercialized. There’s so much commercialism and so much of it is linked to sexual attraction and so the breasts have just become bad. Their real purpose has just been negated.

This respondent felt that women were not able to reap the benefits from their unique ability to produce milk

Dilemma 2: Breastfeeding Advocacy and Empowerment Concerns.

“I mean, I know that people say ‘but you’re a lactation consultant, you’re promoting lactation.’ No. I’m allowing women that have chosen to lactate to have a better experience. That’s where I come from.”

The second dilemma experienced by the lactation consultants in their professional practice pivots around the notion of empowerment and choice. The lactation consultants believe in breastfeeding advocacy, but they are also sensitive to allowing women room for empowerment and autonomy in terms of their own body and infant feeding decisions. The respondents explained that breastfeeding advocacy has the potential to make women feel guilty if they do not, or cannot, breastfeed; and, for the most part, they clearly stressed
their preference for advocating women’s empowerment and personal satisfaction. One respondent elaborated on this issue:

> I think it’s really awfully important for infants to get [breastmilk] if they can…but you can offset that with the fact that the most important thing babies need is happy mommies…And I’m not a wild-eyed [advocate]. Do I believe in [breastfeeding]? Yes, that’s why I do this work. But…I support the mommy enormously…you know I help her get to a place where she can verbalize the fact that she sure as heck doesn’t want to be doing this.

This respondent describes herself as spending a lot of energy supporting the mother, even helping the new mom decide that breastfeeding was not the best choice for her. Others expressed similar sentiments. Respondents sometimes blended the first dilemma of understanding maternal subjectivities with an explicit recognition of how this interacts with promoting maternal empowerment:

> For some women it’s just not going to work for whatever reason – lack of support [for instance]. Yes, I know intellectually the benefits and how important [breastfeeding] is, but I think we also have to respect women’s goals. Help them achieve their goals. It’s their life…some of my LC colleagues may not agree with me but if it’s a woman’s choice not to breastfeed, then I respect that. That’s her choice. I’m not going to look down on her or put her down or think less of her. It’s her choice. She’s living her life.

Respondents did not shy away from using words like “choice” and “empowerment.” One LC said “I love teaching moms how to, to empower them — to tell them this is something they can do…I’m very flexible in the way I teach moms, and I always work with their needs and their wishes.” While the lactation consultants noted that breastfeeding recommendations are currently universal and clear-cut (e.g., they all recited the American Academy of Pediatrics recommendation of exclusive breastfeeding for six months to produce optimal results), they also tempered this recommendation by being attuned to reaching women’s goals, not policy goals.

The LCs generally thought that the policy recommendation of six months exclusive breastfeeding was an unrealistic, and sometimes disempowering, goal. One LC revealed: “We do lose women ...if they want women to breastfeed for six months. There are a lot of women who can only do three months because once they go back to work they can’t handle the stress and they don’t have places to pump and there aren’t people who are supportive.” This type of response mirrored that of other LCs, who detected serious problems in implementing breastfeeding goals in light of challenges and choices that women face in society. In terms of the DHHS breastfeeding awareness campaign,
one respondent discussed how she and other co-workers decided to put up their own advocacy materials in lieu of the DHHS posters and slogans. She worried that the message was too strong and also “weird,” emphasizing, “Yup. We did our own ad campaign.”

LCs also worried about policy messages because of the added pressure it potentially puts on women. They consistently discussed the need for more support for women so that breastfeeding will become more accepted in society. They were hesitant to subscribe to widespread policy messages when general U.S. culture, in their minds, has not yet accepted breastfeeding. The respondents toggled between their belief in breastfeeding ideology and the realization that it might not always be empowering for women to choose breastfeeding in contemporary culture. This lack of cultural security and support for breastfeeding, the respondents explained, potentially hinders mother-baby bonding and female empowerment. So, they were particularly attuned to the guilt women might face with policy messages. One respondent noted that her job is not to induce guilt: “I know many, many lactation consultants and I know we for the most part would not make a mother feel bad because she doesn’t breastfeed. That’s not our role. Our role is educators... We support a woman who decides she is going to breastfeed and a woman who decided she is not.” Another LC tried not to be judgmental, explaining that even if a woman tries breastfeeding once, then that mother deserves “recognition and support.” And when pressed about whether she values a woman’s choice to make a variety of infant feeding decisions, this respondent affirmed that this is the case:

*Respondent:* …it’s important that we give it our best shot...it’s somebody’s choice and once they make the choice you can support them as much as they need.

*MW:* It sounds like you support [the mother] no matter what once the choice is made?

*Respondent:* Yeah. Whatever they want to do. It’s up to them.

Many of the respondents saw themselves in the role of educator, not in the role of placing blame. The respondents explained that they see themselves as assisting women to make informed decisions for themselves. However, a minority diverged from the dominant narrative of working to remove guilt from the infant feeding experience. One respondent said “it’s too easy for women to not breastfeed in this country. I think they should feel guilty because they’re not giving their baby anything that is just as good.” And another explained that the LC’s “job is to provide mothers with the education to make
the best choice for them, for their baby and their lifestyle, and if they still choose formula over breastmilk then they’ve made...an inferior choice. And that’s not our fault; we’ve done our job to provide the education.” Although these respondents used language like “inferior choice” and “should feel guilty,” their narratives still included recognition of broader impediments to breastfeeding that lead women to make a different infant feeding choice.

**DISCUSSION**

The lactation consultant profession is one that has emerged within a social context of heightened cultural and political awareness of breastfeeding and infant feeding practices. Within two decades, this subspecialty has grown in popularity, garnered attention, and added a layer of expert knowledge in the health care arena. Avishai (2007) suggests that lactation consultants emerged out of a demand from class privileged women and their complicated breastfeeding realities and she argues that LCs also abet the “construction of breastfeeding as a middle-class mothering project” (2007: 144). The LCs interviewed for this study do not just respond to the needs and concerns of privileged women. Although some of them engage in private practice work, most of the respondents formally work in hospital or clinic settings where they report assisting a diverse group of patients from a range of socioeconomic and citizenship backgrounds.

In working with their patients, the LCs do subscribe to the general philosophy that breastmilk is the best possible form of infant nutrition. Their belief in the benefits of breastfeeding is interesting in and of itself, given research about breast milk contamination (Boswell-Penc, 2006), equivocal research regarding breastfeeding outcomes (Law, 2000; Wolf, 2007a), and high-profile studies that have refuted claims about the importance of breastfeeding in alleviating certain child health issues (e.g., Michels et. al., 2007). While the LCs adhered to the “breast is best” maxim, they also highlighted two particular dilemmas that arise in their advocacy around this breastfeeding message.

First, despite broader policy messages that focus on the infant, respondents in the current study were keenly aware that the infant is not their only patient. They report that the mothers with whom they work divulge a diverse set of reasons about how they can, or want to, feed their infants. Individual, structural, and cultural impediments to breastfeeding emerged as factors that interact with breastfeeding advocacy. That the lactation consultants highlighted women’s subjectivities bolsters previous micro-level research on the complicated aspects of individual women’s breastfeeding experiences, including the feelings of frustration, guilt, and failure that often accompany women’s
decisions about whether or not to breastfeed (Guttman and Zimmerman, 2000; Lee, 2007; Schmied and Lupton, 2001), the physical pain that breastfeeding women experience (Kelleher, 2006), the trouble women report meeting their own standards of what “good motherhood” means (Lupton, 2000), how breastfeeding represents a salient form of embodied labor (Stearns, 2009), and how women experience a diverse set of values and influences while reconciling the knowledge of “breast is best” in their lives (Blum, 1999; Marshall et al., 2007). The lactation consultants in this study also were attuned to the structural and cultural facets of normative mothering in contemporary society, such that they discussed cultural representations of breasts in society (Stearns, 1999), mommy blaming (Warner, 2006), and the “motherhood dilemma” of how to integrate children with work lives (Gerson, 1985), all of which push the lactation consultants to reevaluate their own adherence to breastfeeding ideology.

Second, while the respondents advocate exclusive breastfeeding, they also distinctly want to empower new mothers whether or not they decide to breastfeed. Because the respondents are in the business of helping women, they are particularly sensitive to the choices women have to make. Unlike findings in previous studies of the La Leche League support system (Bobel, 2001; Weiner, 1994), the lactation consultants are pragmatic in their understanding of women’s realities and explicit in their promotion of maternal empowerment no matter mothers’ choices about breastfeeding. As they promote maternal empowerment and choice, the LCs also actively work not to spread the policy message of risk and blame for mothers who do not breastfeed. While policy messages may pressure women to breastfeed, regardless of what is in their best interest, lactation consultants aim to realize women’s goals, not necessarily policy goals. Their attention to personal choice potentially “provide(s) a favorable environment that enhances the mother’s belief in herself” (Flacking et al., 2006: 79). While the lactation consultants adhere to the belief that all women should breastfeed for, at minimum, six months, they also actively work to make these rules less stringent for mothers. And in this way, they counter contemporary public health strategies that tend to stress personal responsibility for health behavior changes (Petersen and Lupton, 1996). In short, the LCs in this study resist the normative policing of motherhood by resisting policy message about the “right,” or even moral, way to mother. The version of motherhood surveillance in the case of these professionals amounts to one that resists broader policing projects that are infused with the ethic of total motherhood.

This study is based on a small, non-random sample of International Board Certified Lactation Consultants. While these findings are not generalizable to
the profession of lactation consulting, this paper initiates a conversation about
the importance of examining this occupation and its role in shaping
motherhood. Moreover, while this study is placed in the U.S. breastfeeding
context, the World Health Organization and global initiatives also
enthusiastically advocate breastfeeding. Future studies should examine lactation
consulting more broadly and more globally, as an understanding of the nuances
of lactation support in different contexts is needed before launching policies
aimed at improving infant health. Breastfeeding advocacy messages should
take into account the work “on the ground” to achieve goals of infant health.
Policymakers and others interested in monitoring breastfeeding might benefit
from taking the experiences of lactation consultants seriously and bringing
them to the table in future discussions about how best to tackle infant health
goals. As other scholars have argued with public health campaigns targeting
child health, variable interpretations of maternal or parental behavior practices
should be considered before a successful policy can come to fruition (Hackett,
2005; Wolf, 2007a). Lactation consultants fill one of the most direct roles of
monitoring and surveillance during the period of early motherhood and, unlike
abstract recommendations from the state, work directly with mothers. As
they engage in this monitoring, LCs are uniquely situated to explain these
different interpretations and practices surrounding an issue about which they
care so much.

**CONCLUSION**

Lactation consultants, as working between breastfeeding policy and new
mothers, have the potential to act as potent regulators and shapers of early
motherhood. While the state is compiling breastfeeding statistics, launching a
concerted effort to increase the proportion of women who breastfeed, and,
in turn, promoting an ethic of infant health irrespective of maternal desires,
my findings reveal that LCs mediate and mitigate the ideology of “total
motherhood” (Wolf, 2007a). First by highlighting the realities and subjectivities
of individual women and, second, by emphasizing maternal empowerment
and choice, professional lactation consultants interrupt normative breastfeeding
ideology. In so doing, they facilitate breastfeeding practices that tailor to each
individual woman and pursue a goal of providing women with an environment
of informed decision-making. This practice may run counter to prescribed
policy messages, but it may also actually serve women and the cause of
breastfeeding most expediently. LCs are unwilling to sacrifice their belief that
“breast is best,” but they also are reluctant to forget their commitment to
mothers’ needs and empowerment. In the way that they do not exploit their
surveillance role, they also avoid making overt judgments about “good” and “bad” mothering. In their version of policing motherhood, the LCs engage in monitoring that intercepts negative messages. Rather than simply serving as a tool of motherhood surveillance, the lactation consultants in this study use their position to positively promote maternal and infant health in the way that is defined as best for and by each mother. This translates into a much more nuanced project of shaping motherhood – one that recognizes the realities of women’s lives as well as the deficiency in policy measures that ignore these very realities.

**Notes**

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2. Much scholarship has been produced on this topic. For one example, see Ehrenreich and English (2005).

3. LLL is reportedly second in membership only to Alcoholics Anonymous among U.S. self-help groups (Blum and Vandewater, 1993).

4. For a recent scholarly debate over the campaign, see Hopkinson (2007) and Wolf (2007b).

5. Women have also been missing from broader health discussions surrounding breast milk contamination and environmental toxins, as gendered surveillance in this arena focuses solely on the health of babies and populations (Casper and Moore, 2009).

6. According to the IBLCE, there are three pathways to becoming a board-certified LC. The pathway taken by most of the respondents in this study refers to health professionals already working in the maternal and child health area (e.g., as an RN). These professionals who wish to add IBCLC to their credential list must complete, at minimum, 1,000 lactation-specific clinical hours. For more detailed information about this credentialing process, see the IBLCE Exam Eligibility Pathway webpage: [http://www.americas.iblce.org/exam-eligibility-pathways](http://www.americas.iblce.org/exam-eligibility-pathways)

7. ILCA is the professional organization for IBCLCs.

8. This respondent highlighted as “weird” the DHHS campaign advertisement that featured breasts depicted as ice cream scoops, along with the message that breastfeeding reduces childhood obesity. Several of the respondents identified this one advertisement as offensive. For a discussion of this particular advertisement, see Kukla (2006).
References


