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Content

The Healing Power of Professional Invisibility .......................... 3
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The Politics of Infant Feeding Choices ................................. 12
Wendy Spinks, RN, RM, B.App.Sc(NIS), MN, Grad.Dip.Adv.NIS(F&CH)
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The Healing Power of Professional Invisibility

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"Critical reflection is an interesting and powerful thing. It can send us on an investigation which can change our lives by leading us to further discoveries about ourselves and others." Annette Street (1995:109).

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"... "care" sounded a strange word to use in the context of family and child health nursing - to me anyway. Caring for my clients doesn't sound right. I do "care about" them, of course, but am I "caring for" them? It makes it sound dependent - that they are dependent on me for care. I feel it's more of a "working with", not "caring for" role as a child health nurse. Yet if I am not caring for my clients then am I really practicing nursing?" (Journal. 18-3-01)

Introduction

As part of my Bachelor of Nursing Honours course, this unit called for me to use the process of critical reflection to explore, in depth, my practice in the area of family and child health nursing. Becoming a parent is a major life transition and a life crisis (Percival, 1994: 296). As part of the universal service available to all families with children, in this state, I work autonomously, in the community, with families of children from birth to school age. I support women and their families in this, sometimes overwhelming, parenting role. I struggle, however, to articulate the value and importance of this nursing. In this critical reflective process, I come to realise the intangible and invisible aspects of my practice relate to the concept of care.

I explore caring from a cultural and social background, revealing how caring and nursing has been devalued, and that I too have questioned its importance. I explore the caring nature of my practice. Developing a trusting relationship, where professional expertise is not highlighted, is shown to have powerful healing benefits. This reflective process brings me to a deeper understanding and awareness that what I do is at the heart of nursing. It is based on care. I dispel any doubts of the value and importance of caring and what I do.

Critical Reflection

Freire (in Street, 1992: 15) asserts reflection does not start with a search for answers but with a search for questions. Reflection is about uncovering the taken-for-granted assumptions of everyday practice. Taken-for-granted practices are by definition hidden and invisible to nurses (Parker and Gardner, 1991-1992: 3; Street, 1995: 2). So the quest is to search for those practices I do without thinking and explore these.
The process of critical reflection used can be described as four stages: reconstructing accounts of practice by recording, or journaling, thick descriptions; deconstructing or analysing and informing these experiences to uncover the issues and meanings present, as well as the historical and social factors shaping the setting; confronting these issues and factors in order to learn and question the underlying assumptions directing practice; and then reconstructing practice with critical thinking to how things can be done differently or how things will be different now (Street, 1991:29; Street, 1992: 16; Taylor, 2000: 197). Keeping a journal to record episodes of practice is the first step to reflecting on, and questioning practice. [1] Once the art of journaling was mastered (another story) the issues needed to be uncovered.

The issues: Making conscious the unconscious

Although assessing health and development are important aspects of the role, reading through my journaling accounts, I could see this was not what I valued the most. This was implied in the following journal extract, of my first interaction with a young family.

"I really felt like a stranger and a professional... This will take time to build a relationship with this family so I feel less like I am considered 'the professional up there'...I focused on the clinical aspects which was what my role was expected to be i think. I acted the part of the health nurse. This made it safe and easier for the parents to accept me....It will be interesting to see how this relationship develops." (Journal: 13-7-01)

I realised establishing a relationship and how I related with the family, were the more important aspects for me. However, in other journal accounts where I have come to know the family, I seemed to doubt the value of my work, or wonder what I was doing in the interactions. I did not see myself as playing a significant role. I felt quite comfortable with the family. I would "sit and listen", or "listen to the parents proudly talking about their baby." I always recorded weighing the baby. Sometimes I would fleetingly question what I was achieving. I did not appear to be doing anything significant or important.

However, when I looked through my journal again, trying to look in as an outsider, I could see patterns emerge. I found the episodes I was recording involved interactions with families in varying complex social situations. Issues included parents or children with disabilities, mental health issues, difficult relationships, depression, and poverty. All were very vulnerable people. Some were in crisis. Yet when I wrote of the interactions these issues were often not apparent. They were in the background or not mentioned at all. At the same time, I did not see myself taking a significant part in the interactions. It was all fairly normal to me. I was taking for granted the fact I can relate well with people who are very vulnerable, in complex social situations, and caring for young children. This is part of my job. But my difficulty articulating what I do, what my practice is, how I related to a mother, or why I behaved the way I did, or said the things I did, was associated with the intangible, almost invisible aspects of my role. I came to realise this large invisible part of my practice was related to the whole concept of caring in nursing.

It is caring which is integral to life and therefore to health. As I came to see, this intangible concept of caring has become so devalued, that I too doubted its significance and therefore my own truly caring, nursing practice. Benner (2000: 105) warns it is the apparent intangibility of caring that can lead to its dismissal. Clarke and Wheeler (1992: 1283) suggest that enhancing our understanding of the meaning of care will lead to our understanding nursing itself.
The Nature of Care in Family and Child Health Nursing

"Caring is nursing, and nursing is caring." states Leininger (quoted in Kyle, 1995: 506). Care is central to nursing (Benner, 1984: 171; Caelli, 2001: 26), but the concept of caring remains poorly defined (Gardner et al. 2001: 32; Kyle, 1995: 506). Perhaps this explains why, early in my journaling, I had recorded my disconcertion around the term "care" in relation to my work, as quoted at the beginning of this paper.

I had automatically thought of caring as the clinical, visible doing for behaviours and tasks of nursing. Kyle (1995: 507) points to the limiting effects of seeing caring as a set of activities and behaviours without seeing as equally important the expressive role involving relationship building and support. Benner (1984: 170) stresses the "...violence to caring..." when making such distinctions. She finds the expert nurse melds these roles. Duke and Cropp (1992: 40) have described caring as the unifying dimension of nursing and "Like the string in a necklace, it holds all the beads together. However in the same way that a string is often hidden, so is caring and, therefore, nursing." So why is this caring so hidden and undervalued? Why was I questioning the value and importance of my caring role? Street (1995: 2) emphasises the need to locate and challenge the culturally created myths in our lives, because of the effect they have on who we are and how we live our lives.

The social devaluing of women and caring

The devaluing of caring, and caring as women's business, becomes apparent when considering the cultural roots of care. Colliere (1986: 95) states "Care is at the very root of women's history, as it is around care that the main part of women's destiny is woven." In the past, the social value of women's care giving was recognised and held status. Their knowledge was valued and built on a body of empirical facts based on accurate and concrete observations and perspective (Colliere, 1986: 97-98). With the rise of academic medicine women's empirical knowledge was considered menial and unscientific. Care practices were progressively eroded (Colliere, 1986: 98). When nursing and then midwifery finally became medically institutionalised professions...

"Any question about what care means ...was diminished.... nursing care practices became overwhelmed by treatment and procedures. Anything related to care became taken for granted, considered unworthy, requiring 'lower skills' and scanty knowledge, limited to routine procedures and 'know-how'.... everything dealing with care was never revealed as part of work. [Care became].... Invisible work done by invisible women." (Colliere, 1986: 102-103).

Thus the devaluing of what is not observable and tangible and able to be described in a scientific manner. The caring components of nursing are now seen as the least sophisticated and subordinate to medical interventions (Pearson, 1991: 199). A recent study showed it was nurses’ technological skills that were seen as important by patients, nurses and the hospital (Gardner et al., 2001: 38). Nursing in family and child health is not a highly technical area - a pair of electric scales is it! Family and child health nurses work mostly on their own, in isolation, in the community. The nurse and family work together in private. The work is unseen and virtually unknown. Comments from the public such as "What a nice job weighing babies" abound. The intangibility and invisibility of such caring was also reflected in my interactions with families, where I realised it was normal for me to have a low profile.
Professional invisibility in relationships

I found, from my journaling, developing a relationship was fundamental in my practice. It was also important I was not prominent in the interactions. This was revealed in recording the following journal extract.

“…I knew immediately that this four-week-old baby was not thriving. His face was drawn and he had a 'worried look' even when asleep. The health assessment confirmed he had not regained his birth weight. I knew then this was going to be difficult. The first time I meet this young teenage couple and there is something wrong. I said nothing about my concern as we sat and talked about how things were going, including the breastfeeding. All the time I was gauging the parents’ response and level of understanding. I was hoping they would say something that could explain why he looked the way he did. They didn't. They were very proud and happy parents. ...They thought he was going fine, although he was “a bit skinny”…

I was finding this a very delicate and difficult situation. I did not know these young people. I needed to make them aware of the gravity of the situation without alarming them or making them doubt their ability as parents. I was able to say everything else was going well, but as they had noticed, he was a bit skinny. I pointed out he had gained weight since coming home from hospital but was not quite back to his birth weight, which has usually occurred by about the third week. This made them aware that he could gain more weight than he had, but did not alarm them too much, I hoped…

We talked of the possibility of waking the sleepy baby for more frequent feeding, and the benefits of this. The parents appeared happy with this. We arranged for me to home visit in three days to see how things were progressing. (Journal. 19-3-01)

I was very aware of my interaction with the young couple. I realised it was very important to me not to come across as the expert who knows everything and tells them what to do, or to convey the impression they know nothing, or are incompetent. My experience and knowledge in this area meant I recognised the problem and knew how it could be addressed. However, I did not want to impose my solutions onto this family. I was trying to give these parents, especially this shy young woman, a sense of control over the situation.

It would have been an easier option for me, to just tell them what to do. However, I recognise that all my knowledge and experience in this area does not make me the one with the answer. The danger in thinking I automatically know what is best in a situation raises the disabling potential I have as a professional (Illich, 1977:18). Imposing authoritative solutions, with the resultant loss of power to the mother, is disempowering, and has a debilitating effect on her well-being and her capacity as a mother and a woman. As Benner and Wrubel (2001: 173) state, "...authentic care seeks to care for the other in liberating, and nondominating ways." It is the relationship and the interpersonal process that I find so important to my nursing and caring, that I find has such therapeutic potential.

Healing potential of relationship

"Nursing is primarily a personal relationship between nurse and patient which fosters the well-being of the patient" state Bishop and Scudder (1990: 11). Caelli (2001: 26) found health-focused care to be undeniably caring in nature, and it involved the nurse engaging in rapport building to support the
other with consideration, respect and dignity. Jerome and Ferraro-McDuffie (1992: 153) use Peplau's 1952 theory to describe the therapeutic relationship as an "...interpersonal process that uses the nurse (as self) to move a patient to desire healing ...by providing information, empathy, non-directive listening, respect, and feedback as an actual treatment modality..." This describes well what I try to do. So it seems strange to read that viewing nursing as a potential therapy itself is considered unconventional (Ersser, 1991: 43). Yet "...fostering the well-being of clients...is the meaning of therapeutic." (Bishop and Scudder, 1996:127).

I realised the healing potential of my practice after reading again a journal entry where I had initially not seen my input as anything much. I had been regularly visiting Mary, her husband Tony, and their five young children, for over five years. Mary had little trust or respect for child health nurses or any authority that would tell her what to do. The family had little personal resources, and little support. By visiting this vulnerable family and focusing on developing the family’s “…personal capability to take charge of their lives and make their own choices” Zerwekh (1991:214), I was invited back and our relationship, based on respect for each other, gradually built up over many months.

I had recorded the following in my journal:
"...I could hear raised voices as I approached the back door.... Mary opened the door for me as she continued crying and yelling at, and about, her husband. (This was not going to be the quick visit I had planned.) Tears were streaming down her face. I hadn't seen her this upset in a long time. Thoughts of the stress of parenting a new baby again, or past depression coming back, crossed my mind. Mary cried to me the baby had thrush in her mouth and on her bottom. She needed to go to the doctor...and they had no way of getting there. She glanced pointedly at Tony, sitting silently in the lounge room. I knew the difficulties posed when a trip to the GP was needed. With no transport, it meant either trips in a bus or finding a taxi fare, which was usually difficult to find. I felt like putting my arm around her, but didn't. Mary did not show affection easily. ...I was able to tell Mary she could now get the ointment from the chemist without a prescription. Once she realised no trip to the doctor was required, Mary calmed down. ...."

The account continues for several pages. Mary mentioned her breastfeeding problems associated with the thrush. She then went on to talk about how hard it was not having a break, she talked of their fear of fresh harassment from neighbours, of the eldest child's ongoing behaviour problems, and recognised she was picking on Tony more. I did not give her answers to anything, just listened. I concluded the journal entry:
"...By the end Tony and Mary were both talking and we were sharing a few laughs. As I was about to leave Mary said thanks and we exchanged a meaningful glance as we said goodbye." (Journal. 3-5-01)

Mary had developed a sense of trust in me. She did not feel she had to change her behaviour as she let me in her home. This situation was not something I had to fix-only Mary could. But I could seek to understand, and in understanding I could support her to realise her own ability to develop her own sense of control.

My just listening was a way of “being with” Mary. This term describes a caring presence that conveys an assurance of personal concern how she is does matter to me (Benner and Wrubel, 1989: 411; Bishop and Scudder, 1996: 41). As Swanson (1993: 355) explains, it is giving “...time, authentic presence, attentive listening and contingent reflective responses…to give simply of the
The Healing Power of Professional Invisibility

M. Shepherd

Nuritinga Issue 4, June 2001

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self...in such a way that the one cared for realizes the commitment, concern and personal attentiveness of the one caring.” It was only on reflection I realised the meaning of the look that passed between Mary and myself.

What words cannot express

It was the glance that says all that words can't express. It was a look of thanks from her for what has happened, the acceptance and valuing of her as a person. The I understand look from me in response, the recognition of the privilege I have been granted in being allowed ‘in’ to help, to care.

There was an awareness of the underlying need for recognition of what and why Mary was feeling the way she was. By acknowledging her pain, her exhaustion, her situation that will change little at present, it made it more bearable. My belief in her, that she can cope, may have provided her a glimpse of hope. It was the accepting of that person the way she is no matter how she was feeling or acting. She is valued as the person she is, at her innermost spiritual level, the core of her humanness (Sellers and Haag, 1998: 338).

This is a privileged level of intimacy that has occurred in our nurse-client relationship. It is a mutual relationship of personal response. It is a personal “I-Thou” relationship as termed by Buber (in Bishop and Scudder, 1996: 45; Carper, 1978: 18). It promotes healing and well-being of the person's inner self. It is nursing. As Swanson (1993: 357) found “...nurse caring frequently consists of subtle, yet powerful, practices which are often virtually undisclosed to the casual observer, but are essential to the well-being of its recipient."

As a family and child health nurse, my practice is at the heart of caring. As an autonomous practitioner of nursing I have the privileged position of working with families at a major life transition period. Health is viewed in its broadest and deepest sense. I am working with women, men and their families promoting their health and well-being. This is a dynamic process that I do not control but can enhance. There are powerful healing benefits when working with vulnerable people in a low-key professional manner. It is not professional power that is important in caring, it is healing power.

Conclusion

This journey of reflection has been enlightening, and I have come to see what I do through a powerful new lens. My questioning of the value and importance of my practice and my difficulty in articulating this sent me on an exploration of caring. That intangible concept that is integral to life, and the basis of nursing. Entwined with women and nursing, its devaluing throughout history was explored. I came to see that the importance I placed in the personal interaction and relationship was well founded. Working in a low key, enabling manner, which did not emphasise my professional status, provided the best opportunity to enhance the well-being of the family I was working with. I came to see that as a family and child health nurse, I was at the heart of caring. My nursing had powerful healing potential.

What I do is caring, it is nursing and it is powerful healing. If I, as an experienced nurse, cannot learn to articulate the importance of what I do as the vital caring that it is, then caring and nursing will continue to be devalued and dismissed. I am fortunate to work in an area where I can practice
holistic health promoting nursing.

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Nuritinga Issue 4, June 2001
The Healing Power of Professional Invisibility

M. Shepherd

Nursing Outlook, 39, (5), 213-217.

[1] To ensure confidentiality, pseudonyms have been used in all journal extracts in this paper.
The Politics of Infant Feeding Choices

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Abstract

By writing herself, women will return to the body which has been more than confiscated from her, which has been turned into the uncanny stranger on display - the ailing or dead figure, which so often turns out to be the nasty companion, the cause and location of inhibitions. Censor the body and you censor breath and speech at the same time. (Cixous 1976, in Weedon 1987:68).

I sat down on the sofa, my intention being to finish the final chapter of a riveting book I had been reading. Ruby spied me from her play spot in the centre of the lounge room. She made her way across the floor, her arms and legs flailing in such an uncoordinated manner, but never the less making good ground as she crawled towards me. She reached my feet and eased herself up to a standing position, wobbling momentarily as she used one of her hands to tap my knee. I put down my book, scooped her up onto my lap and began to sing to her. She listened politely for a few verses and then squirmed and wiggled, lowering herself sideways so that she was lying across my lap. Her head turned back and forth nuzzling into my jumper, not frantically, just patiently and persistently. Her tongue darted in and out, her mouth half open in readiness for my breast that was about to fill it. I lifted my jumper and within seconds she found what she wanted. It was all so automatic now, with no need to worry about the positioning of lips, tongue head and arms. It was like sneezing, our bodies just knew how to do it. With Ruby firmly attached to my breast, I reached across to pick up my book again when our eyes met and we gazed at each other for quite some time. I noticed the kaleidoscope of colours that made up her eyes, tiny jagged arches of blues, browns, greens and all the shades in between, and suddenly Ruby smiled at me. My milk was flowing rapidly now, cascading into her mouth as she gulped and swallowed, and still she could manage a smile. I smiled back and felt the weight of her relaxed body in my arms, her warmth and softness was exquisite. As I watched and felt her feeding, I couldn't help but marvel at the design of it all, Ruby and I together, mother and daughter, the feeder and the fed. We were an architecture so intricate and complex. As she fed I noticed her lips and tongue working together to form a tight seal around my breast, never spilling a drop of precious milk. I marvelled at her arms, always free and exactly the right length to reach up so that her tiny hands could play with my lips or face. My own arms, just the right length to cradle her head in the crook of my elbow while she drank. One of my own hands always free to stroke her head, tickle her foot or hold her hand. As far as I could see, there was nothing left to chance in this miraculous design. A baby feeding from her mothers breast, surely only a woman could have engineered such perfection. Ruby and I caught each others eye once again and smiled, and our hearts broke for the women and children who have had this experience taken from them (Personal
The sharing of an extract from my personal journal, as a means to begin the critical discussion that is to follow, is an attempt to rectify what Adrienne Rich refers to as '...the absentee author, the writer who lays down speculations, theories, facts and fantasies without any personal grounding (1986:x). In offering my experiences as a breastfeeding critique of the patriarchal subjection of women and a means to demonstrate how women's bodies have come to be defined by someone other than ourselves.

As a midwife, who has worked closely with countless women at various stages along the 'motherhood trajectory', and now as a student undertaking postgraduate studies in Family and Child Health Nursing, I am privy to the stories that women share about one of the most pressing decisions facing new mothers, their 'choice' as to how to feed their baby. While countless women 'successfully' breastfeed their babies (myself included), others lament at their inadequacies as a mother, blaming themselves when they find, for whatever reason, that breastfeeding was not possible. It is my intention, in the pages that follow to look critically at the politics of breastfeeding, or perhaps more correctly, the politics of infant feeding choices. In particular, it is my concern that the medicalisation and scientisation of mothering, steeped in humanist discourses to which nursing largely subscribes, creates a situation where women who 'fail' to breastfeed see themselves, and indeed are seen by others, as victims of their own inadequacies. Rather, I will suggest, following Weedon (1987), that the range of contemporary feminisms offer different ways of seeing ourselves as women and moreover:

For a theoretical perspective to be politically useful to feminists, it should be able to recognise the importance of the subjective in constituting the meaning of women's lived reality...This involves understanding how particular social structures and processes create the conditions of existence which are at one and the same time both material and discursive (Weedon 1987: 20).

It is certainly not my intention to further polarise the breast/bottle dichotomy in regards to infant feeding choices, but rather to expose the patriarchal structures in society that contribute to the politics of infant feeding. As I name and claim my position to be feminist, and as I am a nurse who daily shares experiences with women as they feed their babies, it is important to digress momentarily in order to explore briefly the often troubled relationship between feminism and nursing. In doing so we can begin to see the patriarchal devices at play that not only marginalise and silence nurses within the health care system, but subjugate and render powerless childbearing women, and women who have become mothers. In doing so we can begin to imagine other ways of knowing, alternative positions from which to give voice to our experiences as women.

Nursing and feminism

Nursing has not escaped the feminist influence that has so deeply penetrated Western social, political and philosophical thought. Indeed, given the nature of nursing work that has historically, and continues to be undertaken in the main by women, feminist critiques effectively expose patriarchal structures (social, institutional and discursive), that oppress

Nuritinga Issue 4, June 2001
women. Indeed, feminist thought is tantalising to those of us yearning for, '...a world view that values women and that confronts systematic injustices based on gender' (Chin and Wheeler 1985:74). Achieving a global feminist theory without totalising, without mastery however, is the possibility ever at the edge of our horizons (Wicke and Ferguson 1994:9).

Nurses (women) work in a health care system historically dominated by doctors (men) and the resulting oppression creates a situation in which nurses are disempowered, and women's knowledges marginalised. Medical dominance is pervasive and the medical profession have, Street (1992) suggests:

...been able to develop its own norms and values concerning the safe practice of medicine as the normative ones for the nursing profession and the community...The nurses (oppressed) have internalised the image of the doctors (oppressors) and develop a non critical acceptance of the medical model as normative (Street 1992:42).

Medicines insistence on science and truth as a way of knowing, or rather, the only way of knowing, has secured their dominance and subjugated women's knowledges. The language with which the doctor speaks, the language of science, is a totalising modernist, 'man'-made discourse, which has been constructed in the absence of women because women have, by and large, been excluded from the academic institutions in which these discourses were produced and legitimated. Given the long-standing relationship of dominance and oppression, it is not surprising that nurses have adhered so rigorously to scientific principles in their endeavours at nursing research. This reliance continues despite cautions by nurse academics who point out that adherence to empiricism in order to generate assumptions remain dominant, rather than being exposed for critical review (Bruni 1991:181).

Science however, is indeed seductive. The quest for 'truths', for 'absolutes', for 'essences' and 'foundations' have been sanctioned by science, for science has at varying times, Turner (1992:127), notes, '...the way to true being, the way to true art, the way to true nature, the way to true God, the way to true happiness. Nurses practice within a modernist scientific framework where liberal-humanist discourses assume that we are all the self-knowing author of our lives accepting and living with the notion of freedom to chose, and that we posses a rational consciousness that we can exercise at will (Walker 1993:54). My need to establish nursings link with feminism, and the drawing of our attention to the modernist notion of the human subject, will soon become apparent as I move my discussion toward a postmodern* rethinking of the subject and how we can come to understand women's experiences who see themselves, and indeed are often seen by others, as 'breastfeeding failures'.

*The terms postmodernism and poststructuralism are more often than not conflated within philosophical and feminist texts and which I have invariably done within the discussion before us. Some feminist authors attempt to make distinctions between the two with Lather (1991), confessing to sometimes using the terms interchangeably but more often than not taking the term postmodern, to mean the larger cultural shifts of a post-industrial, post-colonial era and poststructuralism to mean the working out of these shifts within the areas of academic theory Many feminists avoid attempts at definition taking postmodernism.
Breastfeeding - The essence of womanhood?

I saw Lisa today who had made an appointment for a six week nurse health assessment for her baby daughter Matilda. We talked for quite a while about lots of things. Lisa seemed to have a lot on her mind and many questions. Adjusting to life with a new baby had presented many challenges to both herself and her husband. We had decided to concentrate on the pressing issues concerning settling and rescheduled the nurse health assessment for a few days time. As we were talking, Matilda, who had been quietly alert began to cry. 'She's due for a feed', said Lisa glancing at her watch. 'Feel free to feed her while we talk', I said. 'She's being bottle fed so I have to heat it up', replied Lisa. 'No worries', I reassured her, and got the things she needed to warm the bottle. With the milk warmed and Matilda happily taking her bottle, Lisa and I continued talking. Lisa explained to me that she had 'tried hard to breastfeed in hospital but Matilda had, 'refused to attach to her breast'. 'Many midwives had a go at getting her on', she said, 'but in the end we just gave up'. Lisa's pregnancy had been induced and after a lengthy labour, Matilda was delivered by an emergency caesarean section for 'failure to progress'. Lisa confided in me her disappointment not only with the way her labour had ended in an emergency caesarean, for she certainly had hoped and planned for a vaginal delivery, but also at her inability to breastfeed her baby. 'I just feel so inadequate', she said. I know breastmilk is best for Matilda and my friends are all breastfeeding, I feel leftout and guilty (practice journal March 16th 2001).

Lisa's story is not uncommon. Many women begin to breastfeed their babies however, for an array of reasons provided to them by 'health professionals', family and acquaintances (i.e. inadequate milk supply, failure to thrive, bad milk), many also come to use formula as the sole means to nourish their baby. The 'Breast is Best' message is loud and clear and has become firmly entrenched in popular culture. Women's magazines, doctors surgeries, Child and Family Health Centre waiting rooms and a plethora of books advocate breastfeeding. Breastfeeding advocates (of which I am one) couch their arguments in science, relying on scientific evidence to promote the 'anti-infective properties of breastmilk, growth factors, calorific values and the ability of breastmilk to change in order to meet the specific needs of the infant (Palmer 1993:83).

Many pregnant women read breastfeeding literature and hear messages that breastfeeding is easy and should come naturally. Take for instance the opening page of a popular breastfeeding manual entitled The Womanly Art of Breastfeeding, which lays claim to be 'The worlds foremost authority on breastfeeding'. The book suggests:

> Breastfeeding a baby - what could be more natural? Just cradle that precious newborn in your arms and offer him your breast. What could be simpler... Breastfeeding a baby is simple and natural. But it takes information and encouragement and some motherly know-how to breastfeed a baby...' (La Leche League International 1988:xiii).

It is little wonder that women experience feelings of guilt, inadequacy and failure when they are unable to breastfeed their babies. Breastfeeding in popular culture is promoted as the essence of womanhood and if we consider, as Weedon (1987:32) does, that subjectivity refers '...to the conscious and unconscious thoughts and emotions of the individual, her sense of herself and her ways of understanding her relation to the world', it is little wonder
that Lisa sees herself as a failure. What the proponents of breastfeeding do, is fail to critically examine the underlying social institutional and discursive factors at play that contribute to women's experiences who, for whatever reason, do not breastfeed their babies.

Poststructuralist feminisms: (re)thinking subjectivity

Modernist notions of subjectivity where the individual assumes responsibility for their thoughts, and actions arising from those thoughts, is both appealing and seductive. There is a dominant assumption within our society that experience gives access to truth and this being so:

From an early age we learn to see ourselves as unified, rational beings, able to perceive the truth of reality. We learn that as rational individuals we should be non-contradictory and in control of the meaning of our lives. This understanding of subjectivity is guaranteed by common sense and the liberal-humanist theory that underpins it (Weedon 1987:80).

Referring to the modernist elusion of the rational all-knowing subject however, Walker (2000:60) muses, '...if I were indeed the rational, logical person who wrote my own script for life, and that when I didn't get the script exactly right for the game that I found myself playing (which, when you think about it, is not such an implausible thought), then who else was there to blame for getting it wrong but myself?' It is precisely this 'victim' way of viewing the world, inherent in modernist thought, which became the very concern that led me to the critical discussion before us. Indeed until very recently, any other way of viewing the world apart than the one I had always known (one dictated by all the seductive elements of humanism and which I was to discover work insidiously at a subconscious level) would simply not have occurred to me. It was the voices of feminist writers who, through their stinging critiques of patriarchy, exposed the exclusion, omissions and erasures of women's experiences from historical and modernist discourses that attracted my attention. Feminist postmodern writers offered me a way to rethink both my own and other women's experiences.

Reading these feminist writers, my consciousness has certainly been raised. If we return our thoughts for a moment to the extract from my personal journal that began this discussion, and where I lamented in the final paragraph that my heart broke for the women begin to see how feminist postmodern positionings move us away from victim blaming arguments, and focus our attention toward definitions of a self that comes to be constructed. These anti-foundational times are indeed exciting and challenging for me, a nurse and mother working alongside other women and mothers, for oppositional thinking hints at transformation. As bell hooks (1990:15) suggests:

Even the most subjected person has hints of rage and resentment so intense that they respond, they act against. There is an inner uprising so intense that leads to rebellion, however short-lived. The space within oneself where resistance is possible remains. It is different then to talk about becoming subjects. The process emerges as one comes to understand how structures of domination work in one's own life, as one develops critical thinking and critical consciousness, as one
invents new, alternative habits of being, and resists from that marginal space of difference inwardly defined (hooks 1990:15).

Postmodernist discourses view liberal humanist assumptions of the modern subject as rational self-knowing authors of their lives incredulously. Central to poststructuralism is an anti-foundational epistemology. The poststructuralist agenda, 'focuses on the deconstruction of taken-for-granted historical structures of socio-cultural organisations within which various versions of the 'individual' have been inserted and, importantly, on the language and theoretical structures with which the individual and social have been written' (Luke and Gore 1992:5).

Let us consider for a moment the notion of language and how, in poststructuralist theory at least, language is considered the common factor in the analysis of social organisation, social meanings, power and individual consciousness (Weedon 1987:21). Weedon (1987) is particularly instructive in her analysis of discursively constructed subjectivities and it is worth quoting her at length:

Language is the place where actual and possible forms of social organisation and their likely social and political consequences are defined and contested. Yet is also the place where our sense of ourselves, our subjectivity is constructed. The assumption that subjectivity is constructed implies that it is not innate, not genetically determined, but socially produced. Subjectivity is produced in a whole range of discursive practices - economic, social and political - the meanings of which are a constant site of struggle over power. Language is not the expression of unique individuality: it constructs the individuals subjectivity in ways which are socially specific (Weedon 1987:21).

The discursive, social and political production of selves that Weedon refers to come to be family, the education system, the media and, as we shall come to hear shortly, the health care system. Individuals are subjected to gender differentiation from birth onwards. We know from a very young age, how girls should behave and how boys should behave, in fact, gender specific ways of raising children, of what is expected from girls and boys, cuts across all social institutions. These social institutions however are patriarchal ones and ones in which a gendered sense of self comes to be constructed.

In order to illustrate the notion of gendered selves, and patriarchal institutions insistence on humanist discourses that rely on truth and common sense in order to fix their versions of reality, let us return our thoughts to Lisa, and her new baby Matilda, whom we met earlier. Lisa expresses her feelings of guilt and frustration at not being able to breastfeed her daughter. It is little wonder Lisa comes to blame herself for what she describes as her inadequacies as a mother. Whilst Lisa's sense of herself as a gendered being has come about from a range of social institutions since her own birth, more recently she has experienced the patriarchal health care system during the 'medical management' of her pregnancy, labour and postpartum experiences as a new mother. We can imagine Lisa during her medically (scientifically) managed labour, struggling to deliver her baby. The language spoken by the doctor is indeed powerful, and Lisa becomes a case who 'failed to progress', necessitating the delivery of her baby by caesarean section. It is only natural for Lisa to search for a reason for her 'failure to progress', and perhaps she is told by the doctor
The Politics of Infant Feeding Choices

that she has an 'inadequate pelvis', a common medical explanation given to women for their long and difficult labours. Medical language (and in particular obstetrical language) which nurses have come to appropriate, abound with terminology to describe inadequacies of women's bodies such as, incompetent cervix, inability to conceive, incoordinate uterine contractions, placental insufficiency, just to name a few. The postpartum period and her experiences of breastfeeding are remembered by Lisa as, many midwives 'having a go' at getting her own baby attached to her own breast. Breast refusal, the nursing diagnosis of a baby unable to feed from its mothers breast, must surely feel like the ultimate failure for Weedon (1987) provides us with a feminist critique of the patriarchal nuclear family in order to illustrate her understandings of the inadequacies experienced by new mothers, and takes our focus beyond the politics of infant feeding choices which has been my concern so far, to reveal the dilemmas, frustrations, and ambivalence experienced by new mothers in many areas of childcare. I suggest, for the reasons just described, that the patriarchal health care system contributes enormously to the feelings of inadequacy experienced by many new mothers. Weedon (1987) tells us:

The inadequacies widely felt by the new mother...who is inserted into a discourse of motherhood in which she is exposed to childcare demands structured by the social relations of the patriarchal nuclear family, may leave her feeling an unnatural or bad parent...The recognition that feelings of inadequacy or failure are common among women in similar positions, that the current organisation of childcare is the result, not of nature, but of social and historical developments in the organisation of work and procreation, and that contemporary definitions of women as mother conflict with other subject positions which we are encouraged to assume, offers the frustrated mother a new subject position from which to make sense of her situation, a position that makes her a subject rather cause of the contradictions which she is living. As the subject of a range of conflicting discourses, she is subject to their contradictions at great emotional cost (1987:33).

If we consider Speedy's (2000:138) comment that, '...the values that dominate our health system are so pervasive and reflect the values of society at large, it is a struggle for nurses to remain aligned to the person rather than the institution', and heed her suggestion for the development of an '...alternative discourse to that constructed and dominated by orthodox scientific discourse characteristics of the medical world', then feminist postmodern positionings are indeed enticing for nurses. I do not suggest however that postmodern positionings should be taken on without some caution, and heed Probyn's advice that feminists who use postmodern arguments should do so critically, 'watching for holes that could swallow feminism' (1990:178). However, the political significance of decentering the subject and abandoning the belief in essential subjectivity, is that it opens up subjectivity to change (Weedon 1987:33). It is precisely this notion of oppositional thinking that postmodern feminist practices assert that I find so enticing. Here I offer the thoughts of Chris Weedon (1987), not only as a textual strategy to draw this discussion to a close, but as a feminist strategy that begs us to consider a beginning of sorts, as we imagine the potential within nursing, and specifically Family and Child Health Nursing for women to come together and voice their shared experiences:

The collective discussion of personal problems and conflicts, often previously understood as the result of personal inadequacies and neurosis, leads to a
recognition that what we have experienced as personal failings are socially
produced conflicts and contradictions shared by many women in similar social
positions. This process of discovery can lead to a rewriting of personal experience
in terms which give it social, changeable causes (Weedon 1987:33).

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