

Yummy Mummy and the Medicalised Milkmother

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There is *science*; but as an objective discourse, science is not concerned with the subject, the mother as site of her proceedings.

Julia Kristeva¹

Introduction

She didn't notice the five of us standing in white coats at the foot of her bed. She lay back awkwardly as required, propping herself into a half-sitting position with elbows locked, palms flat against the stiff white sheets. A midwife waited by her side. One or two student nurses and an obstetrics registrar lingered.

She grunted. She groaned and moaned. She was indomitable in her beauty, a world beyond my comprehension: big-boned, broad-hipped, and magnificent. We were a bunch of fourth-year medical students, and the consultant didn't ask the woman if she minded when he told us to go in for the last fifteen minutes. She ignored us, didn't even glance our way, and parted her trembling thighs. She laid open her birthing vulva before my four male companions, the midwives, the registrar, and me, and delivered that baby, that miracle of nascent flesh and blood and sinew, without falter under our gaze. Her vulva became something unrecognisable, a great purple fruit peeling back, heaving open. She sweated. She gasped. She grunted and strained from her unnatural position on the bed, so that her face twisted red and her neck bulged. I stood there ashamed at my uninvited presence, furious at the profession I was entering; and tears slid down my cheeks because I knew something holy when I stood before it. I understood numen.

In 1986, within months of leaving the hospital, I had a job as medical officer at the Woolloongabba Aboriginal and Islander Community Health Centre, in Brisbane. There I realised that many of the ideas we doctors had about mothers and babies were culturally determined. When I opened a practice in nearby West End, by now in my late twenties, I learnt from the consulting room that many women felt embarrassed if joyless exhaustion, or outright misery, accompanied their pregnancy. Many felt disempowered as they gave birth, and carried anger and grief about it for years. I learnt that many mothers of very young children felt devalued by society at large, and ashamed of their negative feelings about motherhood.

Then finally, at the age of thirty, I, too, became a mother. In the midst of those sometimes terrifying, often tumultuous and exhausting early experiences of maternity, I coined the term 'milkmother' to denote the

pregnant, birthing, and physiologically or metaphorically lactating woman. A woman is a milkmother, according to this terminology, when she lactates physiologically but also when she lactates metaphorically, offering the particular minute-by-minute physical nurturance that very young children require, regardless of feeding method. And a milkmother, as I was learning myself, is in biological transition, from the pre-maternal years into a lifelong state of maternity; her physiological transfiguration is accompanied by a profound psychological rite of passage.² This paper proposes the need for empowered representations of the milkmother in the cultural imaginary as a counterweight to the milkmother's medicalisation, and is shaped by my own experiences in the early 1990s as a milkmother, and by my twenty-five years as a general practitioner.

The doctor, a masculinist imaginary, and feminism

The imaginary of a culture can be defined as a collection of myths, symbols, and shared assumptions (communicated through religious practice, artistic expression, and the popular media) by which members of that culture make sense of their world, and by which they hope to achieve their full humanity. The Judeo-Christian imaginary, with its separation of matter and spirit, taught us to view the body and, in particular, the maternal body, as unclean and dangerously uncontrolled. Julia Kristeva argues that we frame the body as 'object' due to the breakdown in systems of meaning that occurs in our society when the integrity of bodily boundaries is threatened.³ Belief in the abjection of the maternal body became pronounced when the role of birth attendant started to shift out of the hands of local midwives during the Industrial Revolution, to the new breed of male 'doctor' who laid the parturient woman on her back, anaesthetised her with ether, and extracted the infant with metal blades. By the end of the nineteenth century the nascent medical institution had appropriated the role of birth assistant and advisor in infant care. We promoted hospitalisation for birth, although in the first decades of the twentieth century this hospitalisation was associated with worsened maternal mortality rates.⁴ We promoted breastmilk substitution, despite studies even then that showed formula contributed directly to the rising infant mortality rate.⁵ Those doctors who did support breastfeeding exhorted their patients not to overfeed the baby, advising a routine of three or four hourly feeds, although this advice alone caused, and still causes, lactation failure.⁶

By the turn of the twentieth century, Australian public health officials were blaming the 10% infant mortality rate on maternal ignorance.⁷ Mother blaming has been the shadow to the ideal of the 'self-abnegating, domestic, preternaturally attuned' mother that arose out of the Industrial Revolution, when motherhood became institutionalised.⁸ In order to address the high infant mortality rate, child health centres were

established throughout Australia, run by nurses trained to educate mothers in the principles of 'scientific motherhood'. This method drew on the work of paediatrician Dr Truby King. It promoted routine, hygiene, and measurement, and emphasised a woman's need for training, supervision, and expert knowledge as she raised her children. Perhaps due to reduction in poverty rather than to improved maternal competence, infant mortality rates began to decline, but as the twentieth century progressed, it became increasingly necessary to follow the childrearing advice of medical professionals, in order to be seen as a 'good' mother. The range of possible practices employed by a 'good' mother narrowed, even though the advice varied or even contradicted itself over time.⁹

On the whole, liberal feminism throughout the 1970s and 1980s in Australia did not prioritise women's rights concerning birth and breastfeeding. These feminists were primarily concerned with the crucial issues of equality of the sexes (workplace reform, freely accessible childcare, and economic justice), and the right to safe, free, and legal abortion. The female reproductive body was considered in the context of devising scientific solutions for the problems it posed. The maternity reform movement, in response, critiqued the medicalisation of reproduction and the accompanying decline in women's confidence and autonomy in the childbirth setting and in relation to breastfeeding, arguing that the equality strategy minimised the needs of children and families.¹⁰ Maternity reform activists tended to define breastfeeding and home birth as markers of 'good' mothering, implying that hospital birth and bottle-feeding were the choices of 'bad' mothers.¹¹ Liberal feminists viewed the maternity reform movement as a middle-class project, blind to the economic constraints shaping the lives of less advantaged mothers and their offspring. This tension between liberal feminists and maternity activists pointed to both the significance of the problem of the female reproductive body, and the lack of a discourse by which to navigate.

Tess Cosslett complicates the oppositional discourses of medicalised and natural childbirth in a study of representations of childbirth in twentieth century women's writing. She examines the growing number of women's personal accounts of birth in literature, celebrating the 'inscription of their hitherto marginalised subjectivities', at the same time showing that these subjectivities, including the natural childbirth movement, 'have been culturally constructed by prevailing discourses and cultural practices'.¹² She writes that 'it is only "audience" point of view narratives that are able to give single and simple accounts of childbirth: experienced from the centre, that "centre" becomes diffuse, multiple, fractured'.¹³

In Australia, the tension between liberal feminists and maternity activists proved fertile ground for the rise of corporeal theorists like Elizabeth Grosz, Vicki Kirby, and Alison Bartlett, with their nuanced and

complex theorising influenced by post-structuralist feminism. Corporeal theorists argue that liberal feminism accepts the dominant Western view of the self that is located in the mind rather than in the mind-body continuum. Grosz, for example, proposes 'a refiguring of the body so that it moves from the periphery to the centre of analysis, so that it can now be understood as the very "stuff" of subjectivity';¹⁴ Kirby explores the 'literacy' of bodies; and Bartlett critiques the narratives that shape contemporary breastfeeding discourses.¹⁵ These and other theorists offer radical new ways of reading and speaking the female reproductive body, opening up alternative frameworks for the relationship between motherhood and the political.

Against the background of such theorising, a stronger alliance between some aspects of the maternity reform movements and liberal feminism began to emerge in Australia from the 1980s onwards. Important changes have occurred in medical attitudes to the new mother over the ensuing decades. In hospitals today, women take a more active role in labour, newborns room in with mothers, formula is no longer routinely used in nurseries, and hospital stays after birth are short. Many mothers continue breastfeeding while they return to either part-time or full-time paid employment. The alliance between the maternity reform movement, liberal feminists, and breastfeeding activists has made important gains as they reclaim the milkmother's right to autonomy, respect and choice.

Yet despite these gains, the cultural imaginary of the post-industrial West remains fundamentally masculinist, and the milkmother's body, with her fluid boundaries or, to adopt Grosz's term, her 'volatility', continues to be represented as abject.¹⁶ The belief that the maternal body is untrustworthy and 'not enough' shapes medical practice and research, and because the mother's body remains colonised, as Grosz argues, by these discourses of biology and medicine, the guiding assumptions of the medical profession have tangible effects on the bodies studied.¹⁷ We continue to represent the transfigurative maternal body in a medicalised language heavily reliant upon cultural stereotypes and machine metaphors.¹⁸ It is not surprising then, that my milkmother patients often imagine their body throughout pregnancy, childbirth and the early years of childraising to be untrustworthy, unpleasant, and 'not enough'. They believe their bodies are unfit to meet the frightening physiological or psychological demands of this time of life.

The Virgin Mary

In diverse human cultures, rites of passage are associated with mythological context and ritual practice. But there is a relative absence of mythopoeic images of the empowered gestating, birthing, or lactating female body in the West. As a result, in my consulting room new mothers frequently repeat the words of author Fiona Place, as she writes

of her experience of childbirth: 'I am completely overwhelmed. Overwhelmed by fear and bewilderment. No one ever warned me it would be like this'.¹⁹

Our Western imaginary offers us the pregnant, birthing, and (physiologically or metaphorically) breastfeeding woman in just one main figure, the Virgin Mary, ideal of purity and devotion. The Virgin is the mother without a body. She has no sexual desire, no morning sickness, no screams in childbirth, no lochia. She has no engorgement, or difficulty attaching the baby to the breast, no sleep-deprivation, no resentment. She has an ethereal beauty, and is asexual, since she is—as in the 'Litany of Loreto'—'Mother most pure, Mother most chaste, Mother inviolate, Mother undefiled'.²⁰ She is the product of a masculinist imaginary: acted upon, not an agency of movement or flux. I see images of her, young eyes downcast, head slightly inclined, and imagine her anxiety and depression. She is the *Mater Dolorosa*, Our Lady of Sorrows.

Milkmothers need a feminine imaginary to guide them through the physical and emotional ordeal that is associated with any initiation.²¹ How does a woman learn the right way to conduct herself through her extraordinary rite of passage into motherhood without a symbolic that guides her? How does she make meaning of her ordeal? How does she find courage and confidence in her body? What happens to a woman's relationship with her own gestating, birthing, breastfeeding body when the disembodied Virgin Mary is the only image of the maternal divine offered to her, and her mother, and her mother's mothers back through her genealogy for centuries? According to Grace Jantzen, 'a masculinist imaginary ... renders the becoming of the woman subject, if not wholly impossible, at least fraught with ambiguity and partiality'.²² We lack a mythological blueprint for the extraordinary bodily transformation of pregnancy, birth, and breastfeeding. Why would we *not* be afraid?

The medicalised milkmother

Doctors know that unexpected and dangerous things occasionally happen, with devastating outcomes, and that anticipation routinely saves lives and prevents injury. But my profession struggles to contain its anxiety about the maternal body. We extend our vigilance, our fear of catastrophe, into a pervasive belief that the gestating, birthing and lactating body is unruly, capricious, and dangerous. Our belief that the milkmother's body is abject, or 'not enough', promotes a woman's mistrust of her own bodily function. As she internalises this, she too becomes anxious and afraid. Unnecessary and intrusive practices that interfere with normal physiological processes, and the neurohormonal effects of fear and anxiety, trigger costly cascades of preventable technological or pharmaceutical intervention.²³ This is how the milkmother's 'not enough' narratives, based on physiological misconceptions, become self-fulfilling prophecies. The imagination is a

biological event: the immune, neuroendocrine and neuromuscular systems of the human body alter in response to the imagination and associated emotions, mediated by a host of hormones, neurotransmitters, and immune factors. 'Not enough' is the dominant narrative of my pregnant, birthing, and breastfeeding patients: I wasn't dilating, the baby was too big for my pelvis, I didn't have enough milk, nothing I do can settle him, if I spoil him he'll never stop. In the absence of a feminine imaginary, the masculinist imaginary purveyed by my own profession writes itself into the milkmother's physiology.

At present, the general practitioner continues to be the gatekeeper to antenatal care in Australia. As Janemaree Maher observes, 'the healthy body in pregnancy is, in our culture, primarily defined through medical knowledge'.²⁴ Most babies are born in hospital delivery suites, within a high-technology, medicalised model of maternity care, despite the recommendation of the World Health Organization that midwifery care is more appropriate for uncomplicated, normal birth.²⁵ Thirty-one percent of Australian births are by caesarean section.²⁶ In Western Australia, the rate of elective caesarean section more than doubled in that state's hospitals over a twenty year period to 2003. This rate rise is not explained by increased risk or need for intervention even though, for both mother and infant, there is an increased risk of complications associated with caesarean section compared to vaginal delivery, and the study raises the possibility 'that maternal pressure may also be influencing obstetric practice in Western Australia particularly in the private sector'.²⁷ It is not surprising that so many women give birth under the knife: when we are frightened of our reproductive bodies, we generate 'flight or fight' hormones that interfere with the normal physiological processes of reproduction, or we are persuaded to request technological solutions, which put us at risk of a costly cascade of obstetrical interventions.²⁸ I share Maher's view that 'embedding birth ever more deeply in paradigms of stress and trauma in conjunction with our growing sense that we can *and should* control our bodies is moving us further away from an ability to use the resourcefulness of our physiologies in birth'.²⁹

Attempts to provide alternative, less medicalised options for women have been regularly undermined. For example, the Royal Brisbane and Women's Hospital Birth Centre, staffed by midwives, has endured constant political pressure, even though it turns away many more patients than it can accept.³⁰ The president of the Queensland branch of the Australian Medical Association even described this centre as 'the killing fields', a description he was later obliged to retract with a public apology.³¹ Australian obstetricians remain afraid that a move towards normalising low-risk pregnancy and birth will result in adverse outcomes, despite evidence to the contrary.³² As this article goes to press, the opportunity to make a significant shift towards midwifery-led

care, in the context of health system reform and Medicare rebates for midwives, has been, in the view of midwives, seriously constrained by the medical lobby.

Concerning lactation, Bartlett writes: 'there is very little written on breastfeeding as an embodied experience, as a thoughtful intelligence, as a creative corporeal model'.³³ Instead, the medicalisation of breastfeeding triggered a global decline of lactation in the twentieth century, with negative health effects for mothers and infants. First, medicalisation inhibits women's ability and will to lactate through practices that undermine establishment of supply, inadequate medical training about the management of breastfeeding problems, and a pervasive belief that breastmilk substitutes are 'good enough'.³⁴ Second, the medical version of breastfeeding advocacy artificially shortens the duration of breastfeeding, since infants are biologically encoded to expect two or more years of breastfeeding at the beginning of life.³⁵ Third, medicalisation of infant feeding coincides with a loss of cultural memory of diverse breastfeeding practices, such as prolonged breastfeeding, cross-nursing, using breastmilk as remedy or food, and the breastfeeding of the children by grandmothers and aunts, so that the range of practices that constitute normal breastfeeding behaviour has become extremely narrow.³⁶

Cindy Stearns' study of American women's attitudes to breastfeeding in public found that most women 'proceeded with their breastfeeding as though it were deviant behaviour, occurring within a potentially hostile environment'. The mothers 'uniformly emphasized the importance and/or necessity of learning to breastfeed discreetly. Discretion for these women typically refers to not showing the breast—and especially, the nipple—in public'.³⁷ Stearns argues that as long as breastfeeding, like other milkmother work, is not publicly acknowledged but remains hidden from other women and the broader society, it will be devalued.³⁸ I extend her argument: as long as breastfeeding remains hidden, women will also struggle to learn the skills of breastfeeding, due to an absence of role models. Learning about breastfeeding by observation is important, but both the oral history and role-modelling components of the intergenerational transmission of breastfeeding knowledge in the West have been disrupted.³⁹ As long as breastfeeding is not highly visible, it remains easy for policy makers to underfund breastfeeding educational and professional support.

Alison Bartlett, Anne Manne, Fiona Giles, Julie Stephens, and Jennifer Sinclair are among the Australian theorists who argue that the breastfeeding mother is radically subversive because she challenges us to abandon the oppositional discourses of independence and dependence, and instead conceptualise our humanity in terms of relationality and interdependence.⁴⁰ These theorists maintain that a breastfeeding mother contests the unhealthy values of capitalist

societies,⁴¹ by living out a subjectivity that privileges ‘the relational over the independent and autonomous, the polymorphous, embodied subject over the Cartesian, Western, phallic self’.⁴² They maintain that the slow, chaotic, repetitious temporality of breastfeeding and early maternity contests the linear, scramble-to-the-future quality of modern, new capitalist time. Sinclair suggests that maternity (and, therefore, breastfeeding) draws ‘satisfaction from “being”, rather than “becoming”’.⁴³ This ‘unproductive’ maternal time, marked only by bodily rhythms and the chaos and disorder of children, and where the hours melt into one another, is ‘so transformative that it does threaten a society based on the individualised pursuit of happiness, wealth and success’.⁴⁴

But only fourteen percent of babies are fully breastfed until six months, as is recommended in the Australian dietary guidelines; only forty-eight percent of women offer any breastmilk at all to their babies by six months of age.⁴⁵ The negative effects on infant and maternal health of formula feeding are widely underestimated.⁴⁶ Although we know that ninety-nine percent of women have enough milk; that almost all women are biologically able to feed twins; and that oversupply is the dominant breastfeeding problem identified by lactation consultants in Australia, the most common reason given by mothers to explain discontinuation of breastfeeding remains ‘not enough milk’, and this belief is quickly adopted by immigrants from other cultures who settle in Australia.⁴⁷ The government has recently released the National Breastfeeding Strategy 2010–2015, which aims to protect, promote, support and monitor breastfeeding, and breastfeeding advocates keenly await its implementation.

Up to fifteen percent of mothers suffer clinically diagnosed perinatal depression.⁴⁸ Up to seventy percent of new mothers experience anxiety and unwanted, intrusive, negative thoughts about their infant.⁴⁹ Perinatal anxiety and depression—that is, the distress of the milkmother—is a complex phenomenon embedded in the dynamic and interacting psychosocial and physiological realities of a society characterised by the nuclear family and a devaluing of motherhood. Joan Raphael-Leff observes that ‘postnatal distress is a function of interpersonal, physical, economic or socio-cultural factors’.⁵⁰ Despite this, a reductionist, biomedical model of ‘chemical imbalance’ still dominates in clinical practice: selective serotonin reuptake inhibitors remain the mainstay of treatment of perinatal anxiety and depression by doctors, working in isolation with limited capacity to affect broader sociocultural contexts. Even new research demonstrating the brain’s remarkable neuroplasticity has not yet undone many doctor’s insistence that depression is caused by inadequate levels of serotonin, best remedied by a pharmaceutical boost. Stephanie Brown and her colleagues argue that ‘the “invisibility” of the stresses involved in the

work of mothering goes a long way towards explaining why past researchers have focused on looking for a hormonal cause for postnatal depression'.⁵¹ Many are hoping that the current roll-out of a National Perinatal Depression Initiative in Australia will raise awareness of the problem in the community and in the profession, including its potentially serious affects on some mothers and babies, and offer a more complicated and contextualised approach to a milkmother's distress. Others express concern that there are still inadequate resources available to help every Australian woman diagnosed with mild postnatal anxiety or depression, and that unnecessary medicalisation is occurring.⁵²

Responsible twenty-first century mothers are expected to take all problems concerning infant care to the medical profession, and unsettled behaviours are among the most common complaints in the first months of life. One in five parents report that their baby cries excessively, with the associated risks of premature breastfeeding cessation, child abuse, postnatal depression, and long-term psychological disturbance. But in the absence of easily accessible, multi-disciplinary, community services, clinicians are again commonly tempted to apply a simplistic, reductionist approach to the crying baby.⁵³ Through the 1990s as my own children grew older, my frequent encounters with distressed mothers and babies in general practice, and the large numbers of these babies being diagnosed with 'reflux', led me to research excessive crying in infancy from the perspectives of medical science, ethnopaediatrics, and evolutionary biology. I examined the effect of sociocultural factors upon infant physiology, and the deeply imbedded and unconscious assumptions that informed the medical research into crying babies. Gastro-oesophageal reflux disease has been widely inappropriately diagnosed in crying babies under three months of age, resulting in failure to explore other breastfeeding or organic disturbances; failure to deal with psychosocial determinants and consequences of infant distress; and in the potentially serious side-effects of unnecessary pharmaceutical interventions.⁵⁴ Yet as this diagnosis has waned, other single-focus interventions have come to the fore, posing comparable problems, and the complex factors that feed into infant distress, which arise out of the sociocultural context in which mothers and babies find themselves, are overlooked.⁵⁵

In summary, a relative absence of empowered images of the milkmother in the cultural imaginary has allowed the medical profession to co-opt the way she is represented. Excellent perinatal healthcare is one of the privileges of a wealthy country such as ours, and a right yet to be attained in less developed countries where inadequate medical care in the reproductive years has devastating consequences. Yet the medicalisation of pregnancy, birth and the early years of childraising in the West can also have negative effects upon the well-being of mothers and babies in pregnancy, birth, and the early years of childraising. I

propose we need to create a feminine imaginary to counterbalance these effects, and argue that the recent image of the Yummy Mummy is a brave step in this direction, though the Yummy Mummy remains, nevertheless, a fundamentally masculinist representation.

Yummy Mummy: a brave step toward a feminine imaginary

I first noticed a Yummy Mummy in 2006, beaming at me from a postcard on a shop counter, advertising a health retreat. 'Are you a Yummy Mummy?' the card asked. Another business card handed to me recently featured a svelte blonde in a bikini, and advertised the 'Yummy Mummy Tan and Beauty Bar', for 'your next indulgence'. Like the many references to Yummy Mummy that I have found, these saucy young mothers are used to advertise a commodity that helps them 'look and feel fabulous'.⁵⁶

There are positive aspects of this new phenomenon of the Yummy Mummy. Most importantly, and for the first time in the West, the Yummy Mummy is an image that distinguishes the milkmother—the mother who is pregnant, birthing or caring for very young children—from the mother of older children and adults, celebrating the physical transfiguration of the mother as a unique category of female experience. Second, the Yummy Mummy is aware of and able to speak about her body and her sexuality. The adjective 'yummy' is a play on both the infant's longing to eat from the mother, and the daring portrayal of the milkmother as sexually attractive and desirable. 'Yummy' promises pleasures of flesh, moistness, edibility. A 'yummy' Mummy is not an ordinary, boring, invisible type of mother; nor is she asexual, like the Virgin Mary. She is informal and intimate, a 'mummy' not a 'mother': the two words 'yummy' and 'mummy' rhyme in a pleasing, bouncy way, telling us that the Yummy Mummy is casual, energetic, and cute. Third, the Yummy Mummy vigorously deconstructs sentimentalised myths of the mother. While the Virgin Mary maintains a long-suffering silence about the experiences of pregnancy, birth and young children, and is idealised for her uncomplaining purity and self-sacrifice, the Yummy Mummy complains about the milk years loudly, and without embarrassment. Fourth, the Yummy Mummy aims to help young mothers regain their identity and confidence in a world that values appearance highly. This intention to help has, of course, been contrived by retailers.⁵⁷ But it is impossible to ignore the role that perception of appearance—that of others, and her own—plays in the emotional life of many young Western mothers, and I have come to think there are benefits to be gained from any positive re-framing of her possibilities during this life-stage. The Yummy Mummy, a brand-new, secular figure in popular culture, is confined to a well-off demographic in the West, and may prove transient. She does, however, offer a representation of

the milkmother that is more embodied, complex, and relevant to the postmodern mother than the Virgin Mary archetype.

Yet even though the Yummy Mummy offers milkmothers in wealthy industrialised societies a more comprehensive representation of their transfigurative journey than has been available previously, she remains part of the masculinist imaginary, so that her capacity to represent a milkmother's full potential is limited. The Yummy Mummy's role as a representation of the milkmother is as ambivalent as her relationship with her reproductive body.

She arises out of a new capitalist culture that equates empowerment with the capacity to 'manage' changes in the reproductive body and, as she appears in popular culture, is in her twenties or early thirties, conventionally attractive, white-skinned with regular white teeth. The 'management' of her physical transfiguration occurs, in part, through the purchase of stylish garments, accessories, health products, and cosmetics. From the 1990s, 'marketers began seeing pregnant women as offering commercial possibilities', and with this commodification of pregnancy, the term 'pregnancy chic' entered the English language.⁵⁸ Now, instead of finding maternity wear to disguise the pregnant form, women in my waiting room celebrate their 'baby bumps' with tight-fitting t-shirts and pants or skirts, or expose their swollen belly in a gap between them—an important celebration of the transfigurative maternal body that fails to extend into the postpartum.

The Yummy Mummy passes through the physical transformation of reproduction, but she comes out the other side unchanged, having 'managed' her bodily changes by swiftly re-gaining her pre-pregnant shape after birth, remaining glamorous and attractive to men in conventional terms. Ordinary mothers, modelling themselves on this image, lock into battle with their postnatal body as they attempt to tone, sculpt, and thin it down. Milkmothers commonly become obsessively preoccupied with appearance and body weight postbirth, and we doctors commonly consider this preoccupation normal, even desirable. Being fit and in control are key concepts in the narratives of pregnant and postpartum women of the dual earning middle-class.⁵⁹

The Yummy Mummy is also an ambivalent representation of a milkmother because of an acculturated distaste for her body's wetness. Fiona Giles writes, 'the project to revive the wet status of the breast, that is, the lactating breast, pushes up against fundamental cultural barriers'. She argues that bodily fluids 'cause anxiety if they appear in an unregulated fashion within our culture' and that, for most, 'the idea of the breast remains a dry one, exemplifying containment, neatness and ... exquisite manners'.⁶⁰ The Yummy Mummy doesn't like any of her own bodily fluids, whether menstrual blood, amniotic fluid, lochia, sweat, urine, or leaking breastmilk. She values a deodorised cleanliness and control. She considers bodily excretions, leaking breasts, and body hair

to be abject. Is it any wonder, then, that in our efforts to control the risky leakiness of the lactating breast, we undermine lactation itself and find ourselves abandoning breastfeeding because there is 'not enough milk?'

Neither is it surprising that if a new postmodern mother finds herself to be chubby, leaking milk and lochia, if she is miserable, sleep-deprived, and feeling negative about the child—all characteristics of countless ordinary mothers after childbirth—she feels a failure. The image of the Yummy Mummy teaches her that maintaining a cheerful persona is important if she is to remain attractive. When these feelings of unworthiness, disorientation, dissatisfaction with body-shape, and exhaustion coalesce into depression, the twenty-first century milkmother sees her doctor, who very often will explain that she suffers from a biochemical imbalance in the brain, and prescribe an anti-depressant to help her 'cope'. Manne discusses the increasingly pervasive advice to mothers that they should 'feel less', in order to preserve the efficiency and productivity expected of the modern woman; pharmaceutical intervention is required to manage the effects of complex social and psychobiological forces, if the milkmother is to maintain a pleasing, cheery personality.⁶¹

Another shadow cast by the Yummy Mummy's fun-loving, assertive persona, and related to depression, is a perfectionist and critical attitude towards other mothers. This perfectionism may occur in women for whom feminism has become mainstreamed and incorporated into new capitalist values. It may be a particular problem for older first-time mothers, who are established in their careers, and who are more prone to postnatal depression.⁶² Stephens argues that 'the mother in this contemporary phase of capitalism is caught in a constant process of anxiety-ridden self-improvement'. She writes: 'Scratch a new capitalist mother and you will find anxious references to performing motherhood expertly, efficiently and competently and the desire to do more exercise.'⁶³ Sinclair, defining modernity as goal-directed, future-oriented, and valuing of achievement, argues that the modern milkmother embraces 'the recent rafts of books which "see parenthood as a job, as a new skill to be mastered," and which emphasize children's development and progress and their attainment of goals'. Sinclair observes that 'while these are important aspects of mothering, an undue emphasis on them tends to promote a dismal kind of mothering, one that fails to encourage an appreciation of the pleasures of being with children, and pleasure in their being'.⁶⁴

The Yummy Mummy does not contest these modernist mothering discourses. She may be more fun than the Mater Dolorosa, but women modelling themselves on her pay a price for their bubbly, energetic personalities. As Bartlett observes: 'There is proximity between the desire to erase the body's marks of motherhood and limiting its potentially transformative effects on subjectivity and lifestyle.'⁶⁵ A 'fix-it'

medicalised approach to the deep, biological, and transfigurative impulses inherent in a milkmother's rite of passage offer little opportunity to fashion life-long emotional resilience out of her extraordinary experience.

Conclusion

Health system reform in Australia, bringing with it the National Breastfeeding Strategy, the National Perinatal Depression Initiative, and Medicare rebates for midwives, begins to open up opportunities for the de-medicalisation of the milkmother, at the same time as we benefit from the extraordinary medical technologies at our disposal. In this context, we need to address the relative absence of empowered images of the milkmother in our cultural imaginary, which has significant psychophysiological effects on mothers and babies.

The twenty-first century image of the Yummy Mummy at best only weakly contests the masculinist, medicalised construction of the 'not enough' paradigm, although she claims 'not enough' lustily, with a gutsy self-confidence that eschews shame or morbid introspection. She does make critical gains in rights and autonomy, but is unaware of the extent to which these decisions have been shaped by the broader forces of patriarchal institutions and new capitalism. She wants to hide or remove those aspects of her body or experience that might be culturally abject: leakiness, weight gain, loss of control, grief. She has introjected the cultural qualities that are valued by men, and by the market. The Yummy Mummy derives from the disembodied Virgin Mary in fundamental ways, even though she is a secular image that deconstructs the imaginal world—and, with it, the last remnants of ancestral and mythic context. Despite the 'yummy' that promises moistness, the Yummy Mummy is mostly cleaned up, and dry. She is unable to praise her own 'dripping wet breast[s]', those 'fountains of love and loveliness'.⁶⁶ She moves us closer to a genuinely feminine imaginary of the milkmother, but is still largely formed by the old masculinist paradigm.

The mainstreaming of a feminine imaginary remains an urgently required counterweight to the milkmother's medicalisation. Corporeal theorists have prepared the way. Now it is the responsibility of women contributing to public life—including writers, artists, film-makers, journalists—to bring a flow of diverse, creative, and empowered images of gestating, birthing, and breastfeeding mothers, and of mothers of young children, into public life.

Matriphobic symbolic systems have formed a stable cultural pattern for millennia,⁶⁷ so that the Yummy Mummy is a brave step forward. If, however, we are to move through the rite of passage of the milkmother, minimising the dangers of avoidable medical intervention and selecting appropriate intervention wisely; if we are to sing out 'in praise of the

dripping wet breast', and develop emotional resilience and wisdom as we contend with complex social forces that act upon us as milkmothers, then the creation of a robust feminine imaginary is a physiological and cultural necessity.

Notes

¹ Julia Kristeva, 'Motherhood According to Giovanni Bellini', trans. Thomas Gora, Alice Jardine and Leon S Roudiez, *Desire in Language: A Semiotic Approach to Literature and Art*, ed. Leon S Roudiez, New York: Columbia UP, 1980, 237.

² A woman may become a mother without passing through a milkmother phase, by caring for older children who are not her biological offspring. Many women also identify as mothers for the rest of their lives having once conceived, regardless of intervening miscarriage, stillbirth or death of a child.

³ Julia Kristeva, 'Approaching Abjection', *Powers of Horror: An Essay on Abjection*, ed. Leon S. Roudiez, New York: Columbia UP, 1982, 1–31. Kristeva argues that the abject includes corpses, holes in the body, and the matter associated with these holes, including open wounds, excrement, vomit, phlegm, menstrual blood, sweat, and body hair.

⁴ Marjorie Tew, *Safer Childbirth?: A critical history of maternity care*, New York: Chapman and Hall, 1990.

⁵ Gabrielle Palmer, *The Politics of Breastfeeding*, London: Pandora, 1993, 201.

⁶ Jacqueline Wolf, 'The First Generation of Pediatricians and their Inadvertent Legacy to Breastfeeding,' *Breastfeeding Medicine* 1.3 (2006): 172–77

⁷ Sheryl Brennan, 'Nursing and Motherhood Constructions: Implications for Practice,' *Nursing Inquiry* 5.1 (1998): 11–17.

⁸ Molly Ladd-Taylor and Lauri Umansky, 'Introduction,' *'Bad' Mothers: The Politics of Blame in Twentieth-Century America*, eds. Ladd-Taylor and Umansky, New York: New York UP, 1998, 6.

Ladd-Taylor and Umansky, concerned about the 'extraordinary elasticity of the "bad" mother label' (18), argue that three aspects of modern life exacerbated mother-blaming in the twentieth century: 'the dominance of childrearing experts, the growth of state power, and the flux in gender roles, manifested in the growing number of women in the work force and in feminist movements' (10). According to Susan Maushart, mother-blaming has been re-enforced by a century of psychoanalytic theory, and the personal growth movement, an offshoot of psychoanalytic theory popular since the 1960s, also blames mothers for our personality problems. Susan Maushart, *The Mask of Motherhood: How Mothering Changes Everything and Why We Pretend It Doesn't*, Milsons Point: Random, 1997, 41.

⁹ Ladd-Taylor and Umansky, 'Introduction', 5. For example, in the first half of the century, 'bad' mothers picked the child up as soon as it cried. By the 1980s, 'bad' mothers left their babies to cry.

¹⁰ Kerreen Reiger, *Our Bodies, Our Babies: The Forgotten Women's Movement*, Carlton South: Melbourne, 2001. Catherine Kevin, 'Maternity and Freedom: Australian Feminist Encounters with the Reproductive Body', *Australian Feminist Studies* 20.46 (2005): 7.

¹¹ Ladd-Taylor and Umansky, 'Introduction', 15.

- ¹² Tess Cosslett, *Women Writing Childbirth: Modern Discourses of Motherhood*, Manchester: Manchester UP, 1994, 3.
- ¹³ Cosslett, 118.
- ¹⁴ Grosz, *Volatile Bodies*, ix.
- ¹⁵ Vicki Kirby, *Telling Flesh: The Substance of the Corporeal*, New York: Routledge, 1997; Alison Bartlett, *Breastwork: Rethinking Breastfeeding*, Sydney: UNSW Press, 2005.
- ¹⁶ Elizabeth Grosz, *Volatile Bodies: Towards a Corporeal Feminism*, St Leonards: Allen and Unwin, 1994.
- ¹⁷ Grosz, *Volatile Bodies*, x, xi.
- ¹⁸ Emily Martin, *The Woman in the Body: A Cultural Analysis of Reproduction*, Boston: Beacon, 1992.
- ¹⁹ Fiona Place, 'Apocalypse Now', in *Motherlove: Stories about Birth, Babies and Beyond*, ed. Debra Adelaide, Milsons Point: Random, 1996, 61.
- ²⁰ 'Litany of Loreto', *A Prayerbook for Adults*. Homebush: St Pauls. 256–58.
- ²¹ Hélène Cixous writes in 'The Laugh of the Medusa', in *New French Feminisms: An Anthology*. Ed. Elaine Marks and Isabelle de Courtivron, Brighton, Sussex: Harvester, 1981: 'A feminine text cannot fail to be more than subversive. It is volcanic; as it is written it brings about an upheaval of the old property crust, carrier of masculine investments; there's no other way' (258). For Cixous, asserting the feminine is a feminist act.
- ²² Grace Jantzen, *Becoming Divine: Towards a Feminist Philosophy of Religion*, Manchester: Manchester UP, 1998, 128.
- ²³ Kathleen Fahey, Maralyn Foureur, Carolyn Hastie, *Birth Territory and Midwifery Guardianship: Theory for Practice, Education and Research*, Philadelphia: Elsevier, 2008.
- ²⁴ Janemaree Maher, 'Rethinking Women's Birth Experience: Medical Frameworks and Personal Narratives', *Hecate* 29.2 (2003): 146.
- ²⁵ *Care in Normal Birth: A Practical Guide*, 1996, World Health Organisation, <http://www.who.int/reproductive-health/publications/MSM_96_24/care_in_normal_birth_practical_guide.pdf>
- ²⁶ *Improving Maternity Services in Australia: The Report of the Maternity Services Review* Commonwealth of Australia, 2009.
- ²⁷ C. M. O'Leary, N. de Klerk, J. Keogh, C. Pennell, J. de Groot, L. York, S. Mulroy and F. J. Stanley, 'Trends in Mode of Delivery During 1984–2003: Can They Be Explained by Pregnancy and Delivery Complications?' *British Journal of Obstetrics and Gynaecology* 114.7 (2007): 861.
- ²⁸ Sally Tracy, Mark Tracy, 'Costing the cascade: estimating the cost of increased obstetric intervention in childbirth using population data', *BJOG: an International Journal of Obstetrics and Gynaecology* 110 (2003): 717–724; Michel Odent, *The Nature of Birth and Breastfeeding*, Connecticut: Bergin and Garvey, 1992.
- ²⁹ Janemaree Maher 'Rethinking Women's Birth Experience', 149.
- ³⁰ Jenny Gamble, *Media Release*, Brisbane: Australian College of Midwives Queensland Branch, 2005.
- ³¹ *Midwifery Bulletin*, 2005, Australian College of Midwives, <http://www.acmi.org.au/text/bulletins/1_06_05.html?>, 1 Aug. 2006.

- ³² M. Hatem, J. Sandall, H. Soltani, S. Gates, 'Midwife-led versus other models of care for childbearing women'. *Cochrane Database of Systematic Reviews* 4 (2008): DOI: 10.1002/14651858.CD004667.pub2.
- ³³ Alison Bartlett, 'Breastfeeding Bodies and Choice in Late Capitalism'. *Hecate* 29.2 (2003), 162.
- ³⁴ W. Brodribb, A. Fallon, C. Jackson, 'Breastfeeding and Australian GP Registrars—Their Knowledge and Attitudes', *Journal of Human Lactation*, 24.4 (2008): 422–430.
- ³⁵ Edward Newton, 'Foreword', ed. Patricia Stuart-Macadam and Katherine Dettwyler, *Breastfeeding: Biocultural Perspectives*, New York: Aldine de Gruyter, 1995, x.
- ³⁶ Fiona Giles, *Fresh Milk: The Secret Life of Breasts*, New York: Simon and Schuster, 2003; Fiona Giles, 'Relational, and Strange': A Preliminary Foray into a Project to Queer Breastfeeding', *Australian Feminist Studies* 19.45 (2004): 301–14.
- ³⁷ Cindy Stearns, 'Breastfeeding and the Good Maternal Body', *Gender and Society* 13.3 (1999): 312.
- ³⁸ Stearns, 'Breastfeeding and the Good Maternal Body', 323.
- ³⁹ Alison Bartlett, 'Black Breasts, White Milk? Ways of Representing Breastfeeding and Race in Australia', *Australian Feminist Studies* 19.45 (2004): 341–355.
- ⁴⁰ Anne Manne, 'Motherhood and the Spirit of the New Capitalism', *Arena Magazine* 24 (2005): 66.
- ⁴¹ For example, Sara Loop Ruddick, *Maternal Thinking: Toward a Politics of Peace*, Boston: Beacon, 1995.
- ⁴² Edith Frampton, 'Fluid Objects: Kleinian Psychoanalytic Theory and Breastfeeding Narratives', *Australian Feminist Studies* 19.45 (2004): 366.
- ⁴³ Jennifer Sinclair, 'Motherhood and the Temporal Logic of the Modern', *Arena Magazine* 24 (2005): 95.
- ⁴⁴ Reizi, 'Taking Leave: Working Motherhood and the Politics of Time', *Off Our Backs* 32.1–2 (2002): 18.
- ⁴⁵ 'Breastfeeding in Australia 2001', 2003. Australian Bureau of Statistics.
- ⁴⁶ B. Horta, R. Bahl, J. Martines, C. Victoria, *Evidence on the Long-term Effects of Breastfeeding*, World Health Organization, 2007.
- ⁴⁷ Bartlett, 'Black Breasts, White Milk?' 347.
- ⁴⁸ M. W. Ohara, A. M. Swain, 'Rates and Risk of Postpartum Depression—A Meta-Analysis', *International Review of Psychiatry* 8.1 (1996): 37–54.
- ⁴⁹ J. Abramowitz, A. Schwartz, K. Moore, K. Luenzmann, 'Obsessive-compulsive symptoms in pregnancy and puerperium: a review of the literature', *Anxiety Disorders* 17 (2003): 461–78; Maushart cites estimates that up to 80% of mothers of preschoolers experience mild depression, *The Mask of Motherhood*, 160.
- ⁵⁰ Joan Raphael-Leff, *Pregnancy: The Inside Story*. London: Sheldon Press, 1993.
- ⁵¹ Stephanie Brown, Judith Lumley, Rhonda Small and Jill Astbury, *The Experience of Motherhood*, Melbourne: Oxford UP, 1994, 161.
- ⁵² David Brill, 'Millions Misdirected on Perinatal Initiative', *Medical Observer* Aug 2010 <<http://www.medicalobserver.com.au/news/millions-misdirected-on-perinatal-initiative>>

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⁵⁴ Pamela S. Douglas, 'Excessive Crying and Gastro-Oesophageal Reflux Disease in Infants: Misalignment of Biology and Culture', *Medical Hypotheses* 64 (2005).

⁵⁵ Douglas, 'The Unsettled Baby', in press.

⁵⁶ Quoted on the cover of Liz Fraser, *The Yummy Mummy's Survival Guide*, London: Harper Collins, 2006. After Fraser's book was published, she spoke out publicly about her 'desperate struggle' with bulimia. The interviewer, Julia Stuart, notes: '[Fraser] is selling the yummy mummy myth that pushes mothers to aspire to be beautiful and perfect ... It is exactly the formula that kept her a prisoner of bulimia for so long'.

⁵⁷ Hilary Heard, *The New Moms: As America Celebrates Mother's Day*, Euro RSCG Worldwide Releases Findings on Five New Categories of Modern-Day Moms, Globeandmail.com, 2004 (sighted 10 June, 2008), <http://www.globeinvestor.com/servlet/WireFeedRedirect?cf=GlobeInvestor/config&vg=BigAdVariableGenerator&date=20040504&archive=prnews&slug=2004_05_04_13_1144_1141424#>

⁵⁸ Robyn Longhurst, '(Ad)dressing Pregnant Bodies in New Zealand: Clothing, Fashion, Subjectivities and Spatialities', *Gender, Place and Culture* 12.4 (2005), 437.

⁵⁹ Rebecca Upton and Sallie Han, 'Maternity and Its Discontents: "Getting the Body Back" After Pregnancy', *Journal of Contemporary Ethnography* 32 (2003), 670–692

⁶⁰ Fiona Giles, 'Fountains of Love and Loveliness: In Praise of the Dripping Wet Breast', *Journal of the Association for Research on Mothering* 4, no.1 (2002), 8–9.

⁶¹ Manne, 2005, 48.

⁶² Susan Bewley, Melanie Davies and Peter Braude, 'Which Career First?' *British Medical Journal* 331 (2005), 588–89.

⁶³ Julie Stephens, 'Beyond Binaries in Motherhood Research', *Family Matters* 69 (2004), 88–89.

⁶⁴ Sinclair, 'Motherhood', 94.

⁶⁵ Bartlett, 'Breastfeeding Bodies and Choice in Late Capitalism', 154.

⁶⁶ Giles, 'Fountains of Love and Loveliness', 7.

⁶⁷ The stability of matrophobic symbolic systems is discussed by Diane Jonte-Pace in 'New Directions in the Feminist Psychology of Religion: An Introduction', *Journal of Feminist Studies in Religion*, 13 (1997), 63–130.

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