

**AVOIDING BOOBY TRAPS AND WHIPPING UP PUMPKIN-SPINACH
PURÉES:
A CRITICAL NARRATIVE ANALYSIS OF PEDIATRIC NUTRITION BIRTH
THROUGH THE FIRST 12-MONTHS**

A Dissertation

by

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ABSTRACT

With attention to parenting, mothering, and fathering in the academy and attention to pediatric nutrition in the sciences, this study meets at their intersection. Using a critical approach to study narrative, this inquiry examines pediatric nutrition instruction birth through 12-months that is targeted to parents. The aim of this study is to examine how pediatric nutrition instruction construct master (dominant) and counter narratives that determine what constitutes good parenting. Critical narrative analysis reveals that the maternal role is foregrounded and positions mothers as responsible for pediatric nutrition decisions based on expert recommendations. The master narrative, moderate naturalism, limits good decision making to breastfeeding in the first 4-6 months. The focus on breastfeeding within moderate naturalism highlights the postfeminist-individualization of the maternal role to self-educate about nutrition, self-diagnose breastfeeding problems, and self-govern the body. The totalizing role of mother is evidenced in the social expectations related to education, health enhancement, risk aversion, and cultivating a healthy eater.

The two counter narratives, synthetic acceptance and strict naturalism, are in dialogue with yet resist the master narrative. First, synthetic acceptance resists “breast is best” constraints on feeding by legitimizing formula feeding as acceptable but inferior. Mothers within synthetic acceptance enact totalizing motherhood through feeding education, control over the scene and feeding process/products, and formula-matching. Synthetic acceptance simultaneously seeks legitimization through maternal storytelling

and delegitimizes itself through guilt discourse. Second, strict naturalism resists motivations for feeding choices and the characterization of the apolitical mother in moderate naturalism. Within strict naturalism the maternal role is politicized. Paradoxically, maternal feeding responsibilities reify traditional gender roles and promote domesticity, but they do so in a way that empowers women to enact environmental advocacy. Strict naturalism features mothers who are health literate, environmentally-active, equipped to make homemade organic baby food, and pursue environmental advocacy. By politicizing motherhood, counter narration has the potential to shift from post-feminist-individual frameworks within moderate naturalism to feminist-cooperative frameworks in counter narration. Practice-based recommendations are made to redress the totalizing implications of pediatric nutrition instruction on mothers, limitations on legitimate feeding choices, and neglect of paternal roles.

DEDICATION

To my love, Tyler, thank you for your unconditional love and support.

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CHAPTER I

INTRODUCTION: PREFACE AND REVIEW OF LITERATURE

“For what research areas do you wish to be known?” or, “Describe your research agenda,” are common prompts in conversations amongst graduate students, in professors’ offices, and in the mix and mingle of conventions. The weightiness and finality of these questions in terms of professional identity might produce anxiety in some young scholars, but my answer requires little hesitation: “I want to research intersections of health and family communication using qualitative methods, primarily narrative analysis.” Intersections of health with family communication about familial roles, household duties, work/life balance, and identity shape the types of questions that drive my research agenda. The decisiveness of my answer to the initial question is a culmination of 1) personal experiences that mark turning points in my life story and 2) exposure to research areas and methods that mark turning points in my research agenda centering on child/family nutrition and feeding practices. The need to preface my dissertation is to be reflexive in the research process about how turning points have shaped not only the direction of my research but also the methodological approach.

Reflexive research resounds with the researcher’s self-aware writing by acknowledging how identity, experience, ideology, and methodology influence the research process and outcomes (Creswell, 2007; Ellingson, 2009). Reflexivity is more than a knee-jerk reaction to postpositivist research’s aims of objectivity. Instead, reflexivity is the responsibility of the qualitative researcher to his or her participants and audience to provide rich, well-developed arguments that illuminate the nuances of the

voices represented in the data including the researcher's voice (Lindlof & Taylor, 2011). This particular research endeavor focuses on written texts rather than participants' life experiences. Nonetheless, the preface functions to expose my identity as mother, the cultural and social knowledges of child feeding that influence me, and the academy's research on child feeding that intersects with and influences my research questions. My aim is to be consciously aware of my own voice in the analysis of child feeding texts and the conclusions that I reach. The following sections are divided by 1) personal experiences that motivate this research and 2) extant literature that has profoundly influenced my approach to research in health and family communication.

Intersections with Child Feeding Experiences

As a mother of three boys, my personal experiences with breastfeeding, formula feeding, and introducing solid foods have undoubtedly affected my interest in pediatric nutrition and family roles. In the Summer of 2005, I began the monthly ritual of visiting my OBGYN's office to monitor the progress of my first pregnancy, a very exciting and simultaneously uncertain time in my life. At the initial conference with the physician, he warmly congratulated my husband and me. The congratulatory remarks were quickly followed by distribution of books and pamphlets about childbirth, maternal and infant health, and, more specifically, breastfeeding. Then, as we exited the office, free copies of the latest *Parenting* and *American Baby* magazines lined the counter (who can resist a free and seemingly relevant publication). This was my introduction to infant and child nutrition instruction – a stack of reading material. After attentively reading these instructional texts, I quickly adopted the belief that breastfeeding must be superior to

formula feeding during the first six months of life. Hook, line, and sinker I began to think in terms of “breast is best.” In the months and weeks leading up to the birth of my son, this belief was strengthened after visiting with several mothers, who I admired, and by reading two books gifted to me by one of these mothers. The two books, *On Becoming Babywise* and *What to Expect When Expecting*, along with the instructional texts handed to me by my OBGYN and lactation consultant in childbirth classes became reference books for me during the first year of my son’s life. A quote from Bernice Hausman’s, an academician who studies popular culture discourses about breastfeeding, work rings true in my experiences as mother, “I know that what felt right to me was (and continues to be) influenced by current trends in child rearing advice available in my social circles and immediate cultural context” (2003, p. 122-123).

Unlike a number of friends who described the emotional roller coaster of initiating breastfeeding in the hospital, Micah, my son, latched on and fed thoroughly on each breast during our two days in the hospital. My husband and I left the hospital with confidence in our ability to feed our son. Everything seemed, for lack of a better word, perfect. What followed upon our return home was quite unexpected for our family. To be quite honest, my breasts were huge and hurt. When my milk came in, the fullness of my engorged breast caused Micah to slip off or latch on poorly as he and I tried to juggle breastfeeding. In tears, Micah and I experienced two sleepless nights and frustrating days of inconsistent breastfeeding. I recall desperate pleas for Micah to just get a little milk. I called friends, met with the lactation consultant, used a breast pump, supplemented with formula in a medicine dropper, searched the Internet for tips, and

reread the instructional texts over and over. Stubbornly, I forged ahead with breastfeeding believing that was best for Micah and me, but I never imagined the magnitude of difficulties that I would encounter over the course of the next eight months – dry, cracked, and bleeding nipples, pumping in a shared office, storing milk, and low milk supply. What had been described as a natural method to feed an infant was anything but natural to me.

During his first year of life, the weight of nutritional responsibility was overwhelming at times. When should I really introduce rice cereal? Should I pump and mix the rice cereal with breast milk or mix it with formula? Should I really wait three days in between introducing each solid baby food? Will overeating certain baby foods increase my son's chances of developing food allergies? Should I make my own baby food? Should I spend extra money on organic baby food? Do processed baby snacks set my child up to prefer junk food and increase his chance of childhood obesity? How do I cultivate an appreciation for a diversity of foods and tastes as I introduce solid foods? The texts that had been instrumental in my decision to breastfeed were not as explicit about introducing solid foods, overcoming a picky palette, or developing long-term feeding patterns. To further complicate matters, it seemed as though there was a different set of nutritional advice from everyone I talked to from grandparents to close friends.

Micah survived the first year of life with an adequate growth rate, and now at six years old with two younger brothers, he is a healthy, active child. Admittedly, child feeding was wrought with more anxiety with my first son than with the next two

children. My adherence to exclusive breastfeeding in the first six months of life dwindled with each child. My concern over waiting three days between the introduction of each new solid food subsided with each child. Even my commitment to introduce fruits last in the solid food line up dissipated with each child. Nevertheless, I have lost sleep, exerted incalculable energy and time, and shed many tears concerned about nutrition and growth of all three of my sons. What I have come to realize over time is that I am not alone in the struggles over child feeding choices and responsibilities.

It never ceases to amaze me how mothers, who do not normally talk explicitly about their bodies or, more generally, about bodily functioning, freely discuss breast size, pain from engorged breasts, sore nipples, the color of their child's stool, spit up, and burping. I have found myself at the local grocery store, visiting with another shopper on the baby aisle about formula brands and feeding your child too much stage one carrots (our children had experienced an orange tint to their skin when introducing carrots for three days straight as their first solid food). More often, my pediatric nutrition conversations take place between friends and family as we seek support from one another. I have answered the phone late at night to compassionately listen to a friend confounded by her son's food allergies and made plenty of late night calls myself to see how friends and family approached pediatric nutrition.

Here is one such conversation via text messaging that took place in June of 2012 after my friend, Jenn¹, asked me a question about scheduling and feeding her three-week old daughter.

Jenn: Liz, Would you question your milk supply if you gave a full feeding and then an hour later she wanted another feeding? I'm confused and getting really tired and don't really know when to do the next feeding. Help?

Liz: As a mom, I would panic first. As an outsider, I would say she might be growing and demanding more. Is she doing this every feeding or is this new? To make yourself feel better, you can always pump to measure how much you are producing and feed her what you just pumped.

Jenn: She's been doing it more and more over the last three days. That's why I'm questioning my milk. I hear her gulp milk so I know she's getting plenty the first go around. I'm having trouble going with the flow. No pun intended

Liz: There are lots of things moms try. I actually supplemented with Daniel, but he was not gaining weight fast enough. Supplementing also meant less milk for me because I did not do well with pumping with 2 other kids to take care of. I also started rice cereal early with all my kids but not this early. Give it a few feedings. She may be hungry or she may want the soothing effect.

Jenn: First*

Liz: :-)

¹ Prior to including the text message conversation, I contacted Jenn to ask permission to use the dialogue in my research writings and ask Jenn how she preferred her identity protected. Jenn granted permission, requested to read the work upon completion, and expressed her desire for her name to be used in the writing.

Jenn: I kind of think she wants it to put her to sleep. I really don't want to get in that habit.

Liz: Is she spitting a lot back up? That is a sign that too much is eaten or eaten too quickly. If you think she just wants to go to sleep, I would try the pacifier and swaddle. What am I saying, when that did not work, I, at times, would let them nurse. It depended how tired of crying I was.

Jenn: That's exactly how I feel!! Lol she's not spitting up at all.

Liz: It is exhausting to guess every cry!

As members of one another's social support network, Jenn and I frequently text message, call, or meet to talk about our experiences as mothers and seek advice. This conversation reflects the challenges that Jenn faced in discerning how to respond to her daughter's nonverbal cues – challenges I remember vividly in my own child feeding narrative. How did Jenn come to the conclusion that her daughter was not waiting the adequate time between feedings? Why did Jenn question her milk supply when she could hear gulping and indicated no shortage of wet or dirty diapers? Why did Jenn resist the idea of pacifying her daughter or putting her daughter to sleep by nursing? Like my narrative that preceded the text message conversation, Jenn's child feeding perceptions and decisions have been shaped by a variety of social and cultural knowledges. In my narrative, written texts and interpersonal networks played the leading role in shaping me. Similarly, Jenn was exposed to pediatric nutrition instructional texts (*On Becoming Babywise* has come up in multiple conversations), has

embodied experiences with her previous children, and is a member of multiple interpersonal networks of young mothers.

Parents, like Jenn and I, are often overwhelmed with the weight of responsibility for their children's growth and development. My head swims with conversations between my husband and I about what and what not to feed our boys and between friends about whether or not to let their 1-year old have a chocolate kiss a grandparent handed her or add rice cereal to a bottle at 3-months with the hope it would help him sleep through the night. Forging ahead with research into a topic so close to my own experiences, I am fascinated by the growing body of research in the social sciences and humanities aimed at describing messages related to pediatric nutrition and child feeding in the first year.

Intersections with Influential Child Feeding Research

In the Spring of 2009 my personal narrative with pediatric nutrition and my research interests merged in a study conducted for an interpretive methods course. The study used in-depth interviewing to gather data from stay-at-home mothers about their breastfeeding and formula feeding experiences. As I collected data and read literature on infant feeding, I was introduced to the works of Bernice Hausman (2003; 2008), Linda Blum (1999), Deborah Lupton (Schmied & Lupton, 2001), and Joan Wolf (2007a; 2007b). The imperatives of pediatric nutrition that I had uncritically accepted and applied came into question. Upon examining the history and controversies surrounding breastfeeding and its related practices (e.g. breast pumping), the cultural, political, and social contexts surrounding pediatric nutrition, more broadly, took shape leading me to

question how messages about responsible mothering were in tension with mothers' experiences. Furthermore, the familial role placed in centered stage was clearly *mother*. While the logic behind spotlighting motherhood is supported by division of household labor research, I could not help but question the gaps in understanding how fathers', parental units', and others' roles were being influenced by the same pediatric nutrition instructional texts that had shaped my own expectations as mother.

Furthermore, the spotlight also honed in on breastfeeding, which caused me to question how breastfeeding and formula feeding messages were connected to more generalized messages about pediatric nutrition. I owe a two-fold debt of gratitude to Hausman, Blum, Lupton, and Wolf for 1) promoting a conscious appraisal of what shaped my personal knowledges and experiences of child feeding, and 2) guiding my research interests toward pediatric nutrition, child feeding messages, and familial roles. This growing body of research calls into question prescriptive messages about how to mother in the context of child feeding and points to gaps in literature on fathering, parenting, and introduction of solid foods.

Reading this Work

Pausing for a moment before I lay out my research questions, review extant literature, and analyze data, I am confronted by the role I play in this process of interpretation.

A portrait of a person will be rendered differently depending on who holds the brush, and that difference is the product of the creativity and the technique of the artist in service of her purposes. It is the artist, and not the subject, who

determines the vision, and it is the critic, not the text or the audience or the method, who authorizes the interpretation. That interpretation may be focused on a single speech, a scientific treatise, a public monument, vernacular rhetorics, or performative traditions, but its aim is not truth, or representation, but illumination. Like painters, when we shed light on a object, we make it *into* something: in short, we make it our own (Dow, 2001, p. 345).

As Dow aptly surmises, I am more than shedding light on pediatric nutrition and family; I am making it into *something*. The *something* I aim to generate is more nuanced understandings of how instructional texts on child feeding shape our understandings of familial roles, responsibility, and nutrition, subsequently, resulting in shifts in how medical providers and writers approach child feeding advice.

Before turning the page to begin reading this study, I ask my reader to engage in reflexive reading as I have engaged in reflexive writing. Rothman (2008) paints a vivid picture, “That room [intended for child feeding] has several doors leading into it. Which door you are coming in – “where you are coming from” – will shape what you see in that room” (p. 1). What door are you entering through? Through reflexive research and writing, I am making explicit the revolving door that I am entering and exiting. Now, I ask my reader to do the same.

Parenthood and Pediatric Nutrition Through One Year

Like many other mothers of toddlers, I have numerous friends that are having their first or second child. In an effort to provide support for one another, we utilize the website TaketHEMEAL.com to schedule meal rotations after the birth of a child. My

husband and I signed up to bring two meals to a couple who had recently given birth to their first child. I was sick for the first meal drop off and, subsequently, was unable to deliver the meal to see the couple and their daughter. By the second drop off, I was in good health and was excited to visit with my friends and meet their three-week old daughter. Upon entering the kitchen, I eyed a drying rack with breast pump paraphernalia on it. One of my first questions after setting the food down was, “How is the breastfeeding going?” Tears welled up in her eyes as she began to describe difficulties with her daughter’s small tongue and latch-on. She told me that she was implementing the nutritional and scheduling advice of *On Becoming Babywise*, but she was considering the switch to formula feeding. She, then, talked about going on the Internet to look up information about weaning because of the emotional and logistical difficulties associated with breastfeeding and pumping. What she said next should not shock me; yet, it did. This first time mom of a three-week old infant said, “I feel like I am a bad mom if I don’t breastfeed.”

How is it that a mother of three weeks already feels the weight of social judgment about her child feeding methods? Why does she think that breast milk is the only acceptable form of nutrition for her child? This anecdote introduces a concern about the messages that parents receive in regard to feeding their children, in particular, the burden of judgment within pediatric nutritional advice from birth through year one. This study analyzes pediatric instructional texts to 1) better understand the master narrative of pediatric nutrition constructed across messages that characterize family roles and plots of good parenting, 2) seek out alternative narratives within the instructional

texts, 3) critically examine the implications of these narratives on the family, and 4) diversify what constitutes good pediatric nutritional parenting by influencing voices of authority on the subject. The overarching research questions driving this inquiry are:

RQ1: How do pediatric instructional messages from birth through one year construct a master narrative of nutrition and plot of parenting?

RQ2: In what ways are the master narrative and its plot of parenting contested and transformed in pediatric instructional messages?

RQ3: How can pediatric nutrition instruction be transformed to include a multiplicity of legitimized narratives?

The following chapter frames this study within literature on parenting and pediatric nutrition by reviewing research on parenting and, more specifically, mothering and fathering. Additionally, Chapter I synthesizes research on pediatric nutrition from the perspectives of medical research and practitioners and of social science and humanities' scholars.

Parenting, Mothering, and Fathering

Considering the research intersections of parenting, family/child nutrition, and narrative, each of the major research areas needs reviewing in order to situate the study of child feeding texts in this body of research and demonstrate how this study extends extant work. Therefore, the remainder of this chapter focuses on parenting research and child feeding research, and Chapter II shifts the focus to narrative and how narrative methods will be employed. Chapters I and II build on one another to form an argument for using narrative to study the social construction of parenting in the context of

pediatric nutrition in order to better understand how various texts construct parental roles and how alternative social constructions may be used to voice the concerns and experiences of a wider range of parents.

Parenting

Parenting research resonates in a number of academic disciplines including communication and is represented in a wide scope of journals such as the *Journal of Family Communication* and *Parenting: Science and Practice*. Research into the issues and practices of parenting vary, but the following list provides a sampling of family communication research in relation to parenting: the transition to parenthood (Shapiro & Gottman, 2005; Stamp, 1994), family communication patterns (Koerner & Cvancara, 2009; Hay, Shuk, Zapolska, Ostroff, Lischewski, Brady, & Berwick, 2009), family communication climate (Barbato, Graham, & Perse, 2003), parental support (Burlison & Kunkel, 2002; Turman, 2007), family privacy management and invasions (Ledbetter & Vik, 2012), work-life balance (Cavendish, 2007; Golden, 2009; Krouse & Afifi, 2007), parental roles (Alberts, Tracy, & Trethewey, 2011; Medved, Brogan, McClanahan, Morris, & Shepherd, 2006), parenting styles (Hamon & Schrodt, 2012), family storytelling (Kellas, 2005; Langellier & Peterson, 2006 and see special issue of the *Journal of Family Communication* on narrative in 2012), health and family communication (Browne & Chan, 2012; Miller, Shoemaker, Willyard, & Addison, 2008; Schrodt, Ledbetter, & Ohrt, 2007), and difficult family issues and communication processes such as jealousy, conflict, and risky health behaviors (Baxter, Bylund, Imes, &

Routsong, 2009; Oetzel, Ting-Toomey, Chew-Sanchez, Harris, Wilcox, & Stumpf, 2009).

More specific to this study, family research has argued that power relationships within the family have perpetuated unequal divisions of domestic labor in regard to dependent care, emotion work, and household duties (Alberts, Tracy, & Trethewey, 2011; Erickson, 2005). Within the family a gender divide is noted between males and females and their performance of nurturing roles, socioemotional management, and household tasks. Females provide the majority of child care and complete the majority of household tasks (Gerson, 2012; Rothman, 1989), including grocery shopping, preparing food, and feeding the family. For example, Bianchi, Milkie, Sayer, and Robinson (2000) concluded through time diaries that mothers' and fathers' housework completion was dependent upon time spent in the labor market with the exception of care for children 12 and under and shopping for the family, which were the primary responsibility of the mother regardless of time spent in the labor market. Meal preparation and childcare are consistently low for males and high for females (Twiggs, McQuillan, & Feree, 1999). Questions arise as to how society perpetuates the maternal role as primarily responsible for child rearing and family nutrition considering changing employment structures in the family. Given the findings on the division of household labor, especially child care and family nutrition, family communication research should extend investigations into how these patterns are reproduced despite changes in females' participation in the labor market and how such patterns may be altered to generate more equitable distributions. In particular, this research is interested in how pediatric nutrition texts create a storyline

for parents and gendered expectations for child feeding and how such storylines may be resisted. In what ways do pediatric nutritional messages reproduce gender inequities in the division of domestic labor? The subsequent two sections delineate between parenting research on mothering and fathering, pointing out how both veins of inquiry contribute to the academy's understanding of parenting and how both may be extended in this research endeavor.

Mothering.

The potent mix of cultural, social and moral knowledges and practices which surround perceptions of motherhood, together with the biological act of giving birth, do not in themselves lead women to feel like mothers on the birth of a child. Indeed each woman needs time to come to terms with and develop a social self as a mother; to jettison previous expectations of an essential, instinctive self as mother. Yet to those around her, family, friends and experts, as soon as her child is born, a woman becomes a mother, this powerful new identity overriding all others (Miller, 2005, p. 103).

Motherhood theorizing and research provides a context for understanding how women's overriding identities as mothers are defined, valued, and prescribed historically and contemporarily. After reviewing various theoretical explanations and studies of mothering, I have noted five characteristics of mothering across the literature: 1) social construction, 2) embodied performance, 3) politicized role, 4) morality implications, and 5) contestation. On one hand, the sex-appropriated role of child bearing is biologically determined, and on the other hand, the gender-appropriated role of mother is socially

constructed. Descriptive theories of motherhood draw their conclusions about the meaning of mother and mothering identities from social discourses about this role. Hays (1996) describes the maternal role as *intensive mothering* due to the totalizing effects of motherhood that require mothers to give themselves over to their maternal role. Douglas and Michaels (2004) use the term *new momism* to describe how historical and contemporary public discourse about mothering shifts a wide range of child-related responsibilities onto the mother, disciplines the mother through public scrutiny, and does not support or provide for maternal needs related to role enactment. Wolf's (2011) description of *total motherhood* emphasizes the risk management of mother. Henceforth, I will refer to these three motherhood theoretical frameworks as totalizing (Intensive Mothering in Hays, 1996; New Momism in Douglas & Michaels, 2004; and Total Motherhood in Wolf, 2011).

Motherhood research explains how social expectations of mothers have shifted primary responsibility for physical, psychological, social, and educational development onto the selfless mother. Hays' (1996) notes that socially constructed gender roles situate motherhood as a primarily domestic enterprise and remain relatively constant despite changing economic and cultural expectations of women. The result is self-sacrifice for the developmental needs of a child – a message that reverberates through news stories, magazine columns, movies, television shows, public events, and popular culture images of celebrities (Douglas & Michaels, 2004). Mothers, in a sense, become medical, psychological, and safety experts in order to care for their children and reduce their exposure to risks (Wolf, 2011).

Such socially constructed totalizing mothering roles reproduce inequality in the division of household labor, emotion work, and dependent care by placing the responsibility for these tasks upon the mother. Research focused on familial roles, in particular motherhood, provides insight into the domesticity associated with good mothering. Gerson's (2010) work uses life history interviews to better understand changing perceptions of family roles. Gerson concludes that while preferences for egalitarian relationships and gender equity in caregiving are high, men and women in their 20's question the possibilities of transcending traditional gendered roles that cast mom in the starring role in the home and dad as the traditional breadwinner. Williams (2001) surmises,

Yet, it is important to use the imagery of negotiation with the recognition that women's gender negotiations reflect not only the relationships between isolated individuals; they reflect people's relationships to their gender traditions. People are involved in everyday negotiations both *with* and *within* their gender traditions (p. 258).

Mothers' gender traditions are steeped in domestic labor, child bearing and nurturing, and socioemotional work. Even when considering recent research about the implications of the *Back to the Basics* movement that values maternal bonding and play over consumerism and science (Thornton, 2011), the responsibility for child development and social attachment still falls to the mother. These various studies and works reaffirm motherhood as a gendered identity that is produced, reproduced, and incrementally altered through social discourses about family and caretaking. Examining instructional

texts that contribute to both the reproduction and resistance to women's gender traditions proves valuable in the effort to alter inequities and promote egalitarianism.

Second, motherhood is an embodied performance. This is visible as we view women lifting growing toddlers to their hips and chasing after their children at a public park. With an emphasis on how the role and meaning of mother is socially constructed, it would be relatively easy to eschew the bodies that perform the lifting and chasing. Indeed, mothers garner models and scripts as to how they may believably perform the role of mother for audiences and engage in performative storytelling that reproduces and resists constructions of the role (Langellier & Peterson, 1993). Yet, mothering performances are more than the text of socially constructed gender roles. Totalizing motherhood is performed by bodies subjected to unrealistic expectations of valorized nurturing mothers and superhuman women (Hays, 1996). Why would a breastfeeding mother endure sore, swollen, cracked, and bleeding nipples to continue to feed her child when painless alternatives exist? What motivates the American soccer mom to race home from an eight hour work day to rush one child to ballet, another to baseball, attend to homework completion, and attempt to prepare a balanced meal? How does her body sustain such continuous activity? The social expectations of mothering are bodily felt in as much as they are emotionally felt.

Additionally, embodied performances illuminate the double binds of motherhood beginning with pregnancy. Buzzanell and Ellingson (2005) and Martin (1990, 1992) demonstrate how pregnancy is a visibility of maternity, a mark on the human body, which affects women's ability to perform as ideal workers and connotes disability in the

workplace. After the birth of a child, women's bodies limit them from simultaneously occupying the private house and public employer's office and, thus, become a site for understanding life-work tensions. Consider the breastfeeding mother who struggles to maintain an adequate milk supply pumping and storing milk at work in order to continue to nurse her infant at home. Consider the mother who has to miss a meeting to care for a sick child, or the mother pressured to shop for and purchase organic products, puree her child's meals in a costly baby food appliance, and freeze meal-sized portions in specialized trays to promote a diverse palette and avoid preservatives. In any case, the body has limits, and those limits exacerbate work-life tensions. The embodied responsibilities of child care need further attention to tease out how such responsibilities may influence the experience of motherhood.

Third, motherhood theorizing draws attention to the political underpinnings of mothering. Gendered constructions of motherhood in relation to caregiving, domestic responsibilities, and economic contributions create double binds for mothers. Over time family structures have changed, increasing the number of single-parent households, co-habitation, blended families, dual income earning households, and the list goes on. Nevertheless, women continue to assume the majority of caretaking responsibilities for children and household duties reifying traditional patriarchy within the home that relegates women to domesticity (Rothman, 1989). When women assume additional roles in the workplace, they are confronted with the demands of entrepreneurialism and the ideal worker (Buzzanell & Ellingson, 2005; Trethewey, 2001; Williams, 2001). The incompatibilities between their private and public role expectations lead to

marginalization of motherhood – domestic duties that preclude full participation in career advancement and vice versa.

Fourth, due to the unrealistic expectations of totalizing motherhood, mothers face identity struggles with what constitutes good mothering – a moral attribution. In their description of the good/patriotic mother, Slattery and Garner (2007) argue that news narratives cast the good mother as a nurturing, self sacrificing mother who protects her child from perceived harms. This archetypal good mother is the moral mother pictured in motherhood work, and the implications of failure are stark. For example, Barnett (2005) exposes how media silence frustrations and depression in the role of mothering and draw attention to women's failures.

The more flagrant the moral violation, the more likely the mother's story will be featured for mass audiences, as evidenced in Andrea Yates' trial – the trial of the stay-at-home mother from Houston, Texas who killed her children. The war against welfare moms that began in the 1990's (Hays, 2004) and the media's portrayal of crack babies during this same era (Douglas & Michaels, 2004) painted vivid pictures of morally repugnant laziness, procreation for funding, and dependence on illegal drugs. Lower socio-economic strata are more susceptible to denigrating labels of bad, poor, and irresponsible mothering in the media, but all mothers are equally susceptible to social and self-attributions of moral violations of mothering. Avishai's (2007) research with privileged mothers (white, middle class, well-educated, professional mothers) revealed that success, goal-driven breastfeeding mothers viewed inability to produce sufficient milk supplies and manage the lactating body as failure. Mothers are subjected to

messages about moral mothering and demonization of violators, subsequently reminding us that mothering is not a neutral process and choices are judged differently. Therefore, research attending to the moral implications of mothering need to identify not only what the moral standards are for good mothering practices but also what the implications are for mothers.

Finally, motherhood is a site of contestation. There is an expressed struggle over the meaning of motherhood and the role of mother. At times this struggle manifests itself in class and race differences (e.g. white upper class women hiring peasants and black women as wet nurses and nannies , as discussed in Blum, 1999 and Williams, 2001). The struggle also manifests itself in the *mommy wars* that pit stay-at-home mothers against career-oriented women (Douglas & Michaels, 2004; Hays, 1996). Furthermore, there are alternative constructions of motherhood that do not adhere to all of the tenets of totalizing motherhood. Studies such as Marshall, Godfrey, and Renfrew's (2007) and Schmied and Lupton's (2001) work with new mothers describe how women adapt their sense of good mothering to their own personal, social, cultural, and economic contexts rather than adhering hook, line, and sinker to the aforementioned expectations of mothering. Nevertheless, even in their work, the women interviewed used salient messages about good mothering (e.g. breast is best) as the basis of comparison for their reconstruction of good mothering underscoring the power of good mothering discourse.

In sum, research investigating the maternal role in families provides insight into how mothering is socially constructed and constrained by the valorized, self-sacrificial

responsibilities and expectations attributed to good mothers. An undercurrent in the theoretical explanations of contemporary motherhood and the five characteristics of mothering research is that discourse essentializes mothers' experiences by applying the same set of general expectations to good mothering despite key differences in culture, socio-economic status, geography, health literacy, or social support systems. The groundwork is paved for valuing multiple ideologies of motherhood, but to do so, a theoretical approach must be articulated in a manner that simultaneously accounts for the aforementioned essentialization and proposes an alternative approach to understanding and practicing motherhood. In part, the aim of this work is to build toward that understanding and to use child feeding discourse from various perspectives to emphasize plurality in motherhood. To move forward toward an alternative approach to mothering would be amiss if it was not understood in light of the body of research on fathering, which has blossomed in the past 20 years (Pickard, 1998).

Fathering. Changing family structures in the US due to divorce, cohabitation, same-sex couples, and adoption coupled with changing patterns of employment and work-related policies have surged an interest in fathering, not just mothering (Draper, 2003; Tanfer & Mott, 1997). With that said, fathering research remains underdeveloped in comparison with mothering research (Pleck, 2012), which is why a broader focus on parenting with a keen interest in similarities and differences between gendered family roles is a much needed approach to better account for both mothers' and fathers' experiences and roles. The following section reviews specific literature that has examined the role and practice of fathering with specific attention as to how patriarchy

has perpetuated social constructions of fathers as ideal workers and breadwinners, subsequently, excusing and limiting them from fuller participation in domestic labor.

As with mothering, fathering expectations and practices are characterized by 1) socially constructed roles, 2) the (dis)embodied performance of these roles, 3) the politicized nature of fulfilling the roles, 4) the moral implications as to how the roles are fulfilled, and 5) the contestation of what it means to be a good father. Fatherhood is a label achieved by parenting a child, whether biological or non-biological (Draper, 2003), and fathering is an ongoing performance of that identity ushered on by childbirth, adoption, or other means. Fatherhood is bound up in gendered constructions of masculinity in relation to a male's relationship with his children.

What it means to enact fathering is steeped in masculine models of caregiving and social expectations of men in a given society (Golden, 2007; Johansson, 2011). Traditional images of masculinity construct fathering roles in terms of securing the family economically and physically, thus emphasizing the father's caretaking role in terms of his role in paid employment (Golden, 2007). As such, these traditional images excuse fathers from much of the domestic labor responsibilities that mothers are expected to fulfill. Casting work or employment as a means of fathering provides a partial explanatory framework for understanding the inequity in the division of household labor and why the inequity has perpetuated despite steady increases in female participation in the labor market. Thus, social expectations of fathering, as breadwinning and ideal worker, fosters patriarchy and limits fathers' participation in domestic labor. Furthermore, critiques of fathering have noted a deficit or inadequacy

model juxtaposed to the totalizing models of motherhood (Golden, 2007). The deficit or inadequacy models emphasize the lack of involvement from fathers in the childrearing process; whereas, totalizing models of motherhood emphasize the extreme emotional, physical, and psychological involvement from mothers in the childrearing process.

Next, fathering is an embodied performance, even if studies of fathering tend to disembody fatherhood. To perform the social expectations associated with fathering, men experience the push and pull of the physical and emotional demands of fathering. Just as we marvel at the working mother who takes her son to soccer practice, helps with homework, and cooks supper, we also marvel at the working father who juggles long hours at the office with attending his children's events, dropping them off at school or daycare, and tucking them in at bedtime. While social constructions of mothering and fathering may legitimize care and household duties differently for different roles, both mothers and fathers bodily experience these roles. Pleck (2012) argues that more attention be given to paternal involvement including father's engagement with childcare, accessibility to his child(ren), and responsibility for care and resources. Attention to such issues emphasizes the need to better understand fathering as an embodied performance. How do fathers experience the process of fathering as an embodied process? And, how is this embodied process experienced similarly and differently than that of their maternal counterparts?

Third, fathering is a politicized role. Because masculine caregiving legitimizes paid employment and familial financial security as a significant role expectation of fathers, one might eschew the double binds that fathers experience. Work-life balance

issues resonate with fathers and mothers alike. Employment policies and practices often preclude paid paternity leave, discourage taking vacation time, and de-legitimize fathers engaging in dependent care that takes them away from work incrementally (Golden, 2001; 2007). These gendered structures reproduce tensions between work-related responsibilities and fatherhood. A trade-off occurs as fathers are expected to forgo increased participation in household duties and childcare in order to perform as the ideal entrepreneurial worker. In either case, mothers and fathers experience a dual-burden through the practical and ideological constraints related to the social expectations of their familial roles (Hochschild, 1989; Such, 2006).

Fourth, moral attributions (self-evaluations and others' attributions) are made of fathering behaviors, expressiveness, and practices. Fathering research has centered on poor attributions of fathering, especially research about the division of household labor, but research is also emerging that identifies and describes models of good or moral fathering. The role-inadequacy and deficit perspectives on fathering critique normative behavior that limits fathers' involvement in childcare (Dollahite & Hawkins, 1997; Golden, 2007). Dollahite and Hawkins (1997) propose *Generative Fathering* as an intervention to what they describe as a culture that dismisses and undervalues fatherwork. *Generative Fathering* is cast as a model of good fathering. In this model, fatherwork admonishes fathers to assume responsibility for acquiring parental knowledges and practices that will enable a more active role in household duties and childrearing. Additionally, Lupton and Barclay's (1997) analysis of popular media,

parenting manuals, parenting research, and men's experiences suggest that fathers are poised for more participatory roles in the family.

Interestingly, research focusing on sports and leisure suggests that good fathering is partially constructed through the father's involvement with family leisure. In Such's (2006) study using interview data from couples, fathers viewed their participation in their children's leisure activities as a means of relating to their children and sharing childrearing responsibilities. Using a constructivist approach, Such (2006) describes fathers' childrearing roles as negotiated in everyday familial activities to emphasize leisure as means of enacting good fathering. Kay (2006) notes, in the special issue on "Fathering through Leisure" in *Leisure Studies*, that legitimizing fathers' contribution to childrearing must subsume the distinctive ways in which couples negotiate childrearing responsibilities and fathers' perceptions of their contributions. Kay (2006) and other researchers including Such (2006) featured in the special issue draw attention to the relational development of fatherly bonds and the division of childcare responsibilities that are intrinsically linked to fathers' participation in their children's leisure activities. As Kay (2006) argues, fathers are more likely to engage in playful activities than routine care activities. Fatherhood through leisure does not negate the contribution of more feminized routine childcare such as meal preparation. Instead, fatherhood through leisure is an alternative construction of fatherhood that legitimizes play and "being with" children as good parenting. While fatherhood through leisure legitimizes childcare responsibilities undertaken by fathers, it still does not address concerns expressed in feminist scholarship about the inequitable household responsibilities placed on good

mothering and how fathers may play a role in its redistribution. Being a good father through bonding and childcare responsibilities becomes equated with leisure regardless of the sex of the children.

Finally, what it means to be a good father and how fathers view themselves is a contested terrain. This is evidenced in such work as Fox and Bruce's (2001) survey data that demonstrate how a father's identity and degree to which that identity permeates his overall identity affects his fathering behaviors/activities. Fox and Bruce note that not all fathers share a common view of their identity or what behaviors and characteristics constitute good fathering. Gerson's (2010) interview data with unmarried, young men shows that constructions of fathering are changing, albeit slowly. The men in Gerson's study reported an overwhelming preference for egalitarian relationships and shared childrearing responsibilities. With that said, the men also voiced their concerns as to the practicality of egalitarian relationships in the current labor market and their preference for traditional bread winning constructions of fatherhood as their back up plan.

Although social constructions of parenting roles are inscribed upon mothers and fathers and reproduce gender inequalities, the literature indicates that mothering and fathering are not essential identities. Golden (2001) notes two challenges facing parents: 1) diverse requirements between different roles such as employee and parent and 2) the diversity of role definitions available such as differing social constructions of good mothering or fathering. In other words, parenting presents a challenging set of often competing expectations. This is evident in expectations surrounding child feeding and family nutrition. The subsequent section narrows the focus of parenting to the context of

pediatric nutrition during the first year of life and integrates how nutrition and feeding literature discusses the role expectations of parents in regard to child feeding.

Family Nutrition and Child Feeding

Issues related to parenting and family nutrition receive widespread media attention from *Time* magazine's May 21, 2012 cover with Jamie Lynne Grumet pictured breastfeeding her three-year old (Pickert) to *People* magazine's article about Laila Ali convincing her four-year old to eat his vegetables (Mascia, 2012). Parents can conduct searches about food allergies and picky eaters with a click of a button and read the latest child feeding tips in *Parenting* magazine. Not to mention, the blogosphere is replete with gourmet baby food recipes and how to plant an organic garden to grow your own baby food. Given the enormity and variant amount of parenting and child feeding messages circulating, the following section introduces literature on pediatric nutrition from birth to one year from two distinct perspectives. First, research on pediatric nutrition from a scientific and medical practitioner perspective seeks to understand and improve health outcomes and has a significant influence on public health policies and perceptions of what constitutes good parenting. Second, research on pediatric nutrition from a social scientific and humanities perspective seeks to understand cultural, social, political, and structural influences and experiences.

Pediatric Nutrition Research in Medical Sciences

Pediatric nutrition research in the span of birth to one year focuses on children's health and physical development by linking nutrition and feeding practices to specific health outcomes and healthy behaviors. In addition to the enumerable articles published

in general medical journals, there are several journals that focus specifically on pediatric nutrition including *Maternal and Child Nutrition*, *Human Lactation*, *Breastfeeding Medicine*, *International Journal of Pediatric Obesity*, and *Pediatrics*. The culmination of this research is reflected in the policy statements and public advocacy efforts of the American Academy of Pediatrics, the American Academy of Family Physicians, and the American Congress of Obstetricians and Gynecologists and in public health initiatives like *Healthy People 2020*.

Pediatric nutrition research in the medical sciences is influential on the development of public health policy, health communication campaigning, and the writing of pediatric nutrition instructional books and articles for lay audiences. The American Academy of Pediatrics (AAP) is an organization comprised of 60,000 pediatricians whose mission is “to attain optimal physical, mental, and social health and well-being for all infants, children, adolescents, and young adults” (*AAP Agenda for Children 2012-2013*, 2012). The updated AAP (March 2012) Policy Statement on Breastfeeding and the Use of Human Milk affirms human milk as the normative and preferred child feeding product from birth to six months of age and continued usage through at least one year. Supporting their position, the AAP cited research that exclusive breastfeeding during different intervals over a one year period lowers an infant’s risk of developing upper respiratory infections, nonspecific gastrointestinal track infections, Sudden Infant Death syndrome, an array of allergies, Celiac disease, obesity, diabetes, childhood cancers such as Leukemia and Lymphoma, and cost of infant care. The AAP recommends the introduction of solid foods between 4-6 months with

continued breastfeeding through at least one year (Greer, Sicherer, Burks & Committee on Nutrition and Section on Allergy and Immunology, 2008), which is consistent with policy statements and publications by the World Health Organization (2007), the American Public Health Association (2007), and the United States Department of Health and Human services (2000). Despite widespread agreement over breastfeeding, research is not always consistent in its support of specific child feeding practices.

While some forms of child feeding practices have been clearly linked to poor outcomes, medical research often has conflicting evidence of health outcomes. For instance, Seach, Dharmage, Lowe, and Dixon (2010) conclude that parents who delay the introduction of solid foods into their infants' diets reduce their children's odds at becoming obese in childhood. Moorcroft, Marshall, and McCormick (2011) conducted a meta-analysis of research on the cause-effect relationship between the timing of solid food introduction and childhood obesity. The meta-analysis revealed no significant relationship between the two variables. In a different line of research, Tromp et al. (2011) conducted research with 6905 preschool age children in a larger study on fetal life until young adulthood. Their aims were to test recommendations that certain foods (e.g. cow's milk, hen's egg, peanuts, other nuts, soy, and gluten), classified as highly allergenic, cause wheezing and eczema symptoms. Researchers found that recommendations to delay the introduction of these foods were untenable. Other illustrations of conflicting and reversing medical research and recommendations related to food allergies are summed up in a 2013 American Academy of Pediatrics news article. Dr. David M. Fleischer (2013) describes the 2013 updated AAP recommendations from

2000. In 2000, the AAP recommended that parents delay the introduction of cow's milk until age 1, hen's eggs until age 2, and peanuts, other nuts, and fish until age 3.

Accompanying the advice in 2000 was a plethora of foods to avoid in pregnancy and during breastfeeding. The 2013 change that cites research like Tromp et al. (2011) overturns these recommendations with one exception – breastfeeding exclusively for at least 4 to 6 months before introducing solid foods.

Such conflicting and changing research conclusions demonstrate the lack of certainty as to what parenting practices may be attributed as good for pediatric nutrition and the need for more flexibility in how good parenting is portrayed in pediatric nutrition instruction. Furthermore, a number of child feeding practices during the first year may not have significant research documenting health benefits but neither does research support these practices as being risky or causing negative health outcomes. For example, formula-feeding research has primarily identified risky health outcomes related to formula-handling – preservation and sterilization (Labiner-Wolfe, Fein, & Shealy, 2008). Therefore, what constitutes nutritious and low-risk child feeding practices and, subsequently, good parenting is often a contested terrain.

Considering the influence of pediatric nutrition research in the medical sciences over what constitutes good parenting, a noted concern is a lack of reflexivity by the medical sciences. Not all forms of pediatric feeding practices are equal, and subsequently, not all parenting practices related to pediatric nutrition are equal. For example, the medical sciences have demonstrated that children consuming fruit juices and carbonated beverages are at greater risk of oral decay (Taji & Seow, 2010).

Understanding this relationship shapes expectations that good parents should monitor the quantity of fruit juice and carbonated beverages they provide to prevent unwanted health outcomes such as cavities.

Overall, the medical sciences have not been reflexive as to the influence their research and recommendations may have on essentializing parents' feeding practices and unreasonably narrowing constructions of good parenting in pediatric nutrition contexts. Johnson (2004) explains how scientific discourse "operates from an objectivist ideology that emphasizes neutrality, disinterestedness, and universality" (p. 346). Research about child feeding preferences, decision-making practices, health outcomes, and methods of promotion has a significant influence on medical practitioners (e.g. pediatricians, family practitioners, gynecologists, nurses, midwives, doulas, and lactation consultants), advocacy and policy influencing organizations (e.g. WHO and AAP), and instructional child feeding texts (e.g. pamphlets produced by WIC and *Parenting* magazine articles). The scientific discourse of pediatric nutrition trickles its way down to parents and influences child feeding attitudes, beliefs, and practices. Of interest to me is not necessarily the experimental, survey, and diagnostic research circulating in the scientific community, but rather how this scientific discourse is translated to laity and generates both understanding and identification.

Parenting magazines, child feeding educational literature, popular books, and even entertainment programming reconstruct child feeding scientific discourse for their audiences in the form of advice, humor, and drama while maintaining the authority and objectivity of science. This advice is consistent with didactic techniques of priestly

discourse and reflects broader cultural ideologies of bardic discourse. Scientific discourse translated for non-scientific audiences shapes maternal and paternal child feeding expectations and reflects gendered roles that are embedded and circulated in popular culture. Therefore, this study is aimed at better understanding the influence of the medical sciences on pediatric nutrition texts targeted to parents, how those texts construct plots of good parenting, and how alternative plots of good parenting need to be considered by the medical sciences to redress the limiting of legitimate parenting plots.

Pediatric Nutrition Research in the Social Sciences and Humanities

In addition to pediatric nutrition research in the medical sciences, social science and humanities scholars have demonstrated an interest in the subject. Within the academy, the body of work on child feeding and nutrition has either reproduced or resisted the directives of the medical sciences and practitioners. First, humanities and social scientific inquiry have reproduced the messages and findings related to pediatric nutrition and the medical community. While this research often assumes a critical perspective, the overarching message affirms the conclusions and imperatives associated with medical pediatric nutrition advice. Second, humanities and social scientific inquiry has challenged the imperatives related to pediatric nutrition during birth through one year, specifically claims that *Breast is Best*. The following section explores both veins of research.

Using Humanities and Social Sciences to Reproduce Pediatric Nutritional Messages from the Medical Community. This section focuses on two scholars' works who have simultaneously offered cultural and political critiques of pediatric nutritional

advice and contests and reproduced *Breast is Best* discourse. First, Bernice Hausman's (2003) book *Mother's Milk: Breastfeeding Controversies in American Culture* uses a critical approach to study the *Breast is Best* message. In her chapter entitled *Breast is Best*, Hausman (2003) argues that representations of infant feeding generate a "paradox of claiming that breast milk is best for human infants but manufactured infant formulas are fine too" (p. 94). Rather than focusing her critique on *Breast is Best* and the research used to support it, Hausman (2003) focuses her critique on bottle feeding messages, dominant cultural discourses, and social structures that undermine the embodiment of *Breast is Best* in practice. For example, Hausman (2003) analyzes formula feeding promotional and instructional materials. In particular, she looks at a chart that matches baby's needs to a formula. Hausman (2003) argues that formula feeding is positioned to reinforce Western values of control, independence, and consumerism through scheduled feedings and purchasing power. Hausman, who exclusively breastfed her own children past year one, renders a different perspective on *Breast is Best* than the works reviewed in the subsequent section. Hausman converges with feminist colleagues in her assessment that breastfeeding is constructed as an optimal choice for women who have the leisure and means to accomplish it but diverges in her assessment that the *Breast is Best* message is for every mother. In order for political, economic, and educational conditions to foster breastfeeding for every mother, Hausman (2003) contends that the privileged (white, middle-class) breastfeeding mothers need to increase their advocacy to promote breastfeeding support through policy changes in maternity and paternity

leaves, medical education, and promotional materials written clearly and accessibly for all mothers.

In a complementary line of inquiry, Amy Koerber's research with lactation consultants (2006) and mothers (Koerber, Brice, & Tombs, 2012) has sought to improve health care experiences and outcomes related to breastfeeding. In Koerber's (2006) study with lactation consultants, other medical professionals, and their clients, she uses Foucault's concept of *pouvoir-savoir* to discuss disciplinary rhetorics of breastfeeding and the ways in which they are discursively and bodily resisted. Relying on Spivak and Biesecker's clarification of *pouvoir-savior* to mean both power and ability, Koerber argues, "Adopting this slightly different translation, disciplinary power can be understood as not only dictating what subjects should do, but also as producing the very rhetorical situations in which they act by specifying what their bodies can do" (p. 91). Koerber is interested in how disciplinary rhetorics of breastfeeding produce contradictory messages that often make breastfeeding impossible. The women in the study described their breastfeeding practices and advocacy as "bucking the system" and a direct challenge to physicians and nurses who undermine breastfeeding efforts (p. 93).

In another study on breastfeeding, Koerber, Brice, and Tombs (2012) apply Babrow's Problematic Integration (PI) to better understand how women receive and understand breastfeeding messages but are unable to actualize breastfeeding outcomes. Focus group data with mothers and their guests revealed three themes consistent with PI. First, the evaluative orientation of mothers demonstrated understanding and favorability toward breastfeeding, but the probalistic orientation demonstrated anticipation of

breastfeeding failure. Second, the divergence between the evaluative and probalistic orientations was mediated by communication with the mothers' friends, family, and media. In other words, the mothers adopted favorable views toward breastfeeding and anticipation of breastfeeding failure by communicating with family and friends (e.g. listening to a friend recount obstacles to breastfeeding) and exposure to media (e.g. advice manuals that describe breastfeeding difficulties). Third, participants described a variety of problems related to information, specifically access to expert information, too much information, and lacking the right kind of information. Koerber et al. (2012) conclude that "women have already internalized the 'should message about breastfeeding, but now, it seems health communication scholars might need to conduct additional research to determine effective and creative ways to communicate the 'can' message" (p. 135).

Research like Hausman's and Koerber's spans disciplinary boundaries and invokes Rakow's admonition to scholars – use research to make a positive difference (2005). Furthermore this research resounds with what Labbok (2008; Labbok, Smith, & Taylor, 2008) and McCarter-Spaulding (2008) describe as feminist activism within pediatric nutrition. Yet, not all feminist activism within pediatric nutrition reproduce the *Breast is Best* message as evidenced in the following section.

Using Social Sciences and Humanities to Critique Pediatric Nutrition

Messages and Practices. There have been a number of exemplary works in the social sciences and humanities that have approached pediatric nutrition from a critical perspective. Linda Blum (1999), Ellie Lee (2007, 2008), Joan Wolf (2007, 2011),

Christina Bobel (2001), Deborah Lupton (Schmied & Lupton, 2001), and Joyce Marshall (2011; Marshall, Godfrey, & Renfrew, 2007) have contributed to the academy's growing interest in breastfeeding and motherhood. The first set of research in this section assumes a macro-orientation by examining larger sets of pediatric nutrition discourse circulating in society while the second set of research assumes a meso or micro-orientation by examining people's infant feeding experiences. To begin, Linda Blum's (1999) book, *At The Breast: Ideologies of Breastfeeding and Motherhood*, critically examines the *Breast Is Best* discourse at its point in history and the social, cultural, and economic contexts that shape its meaning and experience. Blum concludes that breastfeeding discourse, as a lens to examine motherhood and culture, lead to constructions of the *good mother* and the *denigrated* or *othered mother*. The *good mother* has the support of a husband, the scene of a home, the education associated with middle and upper socio-economic strata, and the label *white*. Whereas, the *denigrated* or *othered mother* may lack the support of a husband, may or may not have a safe or stable home, lacks education and resources, and is marked by minority racial status. Thus, pediatric nutritional ideals are achieved by the efforts of a privileged class of mothers.

Extending Blum's work, both Ellie Lee (2007, 2008) and Joan Wolf (2007, 2011) examine breastfeeding and motherhood through the lens of a risk culture. More pointedly, Wolf (2007, 2011) offers a critique of the scientific evidence use to fuel the *Breast is Best* discourse and the social pressures on mothers to perform extreme risk aversive feeding methods regardless of contextual factors. Lee's (2007, 2008) and Wolf's (2007, 2011) respective works not only draw further attention to the classed and

raced constructions of breastfeeding but also draw much needed attention to the cultural shifts of risk aversion that position mothers as responsible for protecting and self-sacrificing to avoid formula feeding “risks.” Yet, breastfeeding becomes a risk averse project undertaken by mothers based on questionable scientific evidence and myopic breastfeeding advocacy (Wolf, 2011).

Second, research on infant feeding has assumed a meso or micro orientation by using data collection and analysis methods that focus on parents’ experiences. In one such example, Christina Bobel (2001) conducted ethnographic research with La Leche League members including participant observation of meetings and interviews. Bobel (2001) found that the breastfeeding mom’s and La Leche League organizational messages generated contradictions about good mothering. Using the term *bounded liberation*, Bobel (2001) describes how, on one hand, breastfeeding empowers women to perform motherhood in a uniquely feminine way and reclaim the sexualized female body, but on the other hand, breastfeeding represents a return to biological essentialism that relegates mothers’ roles to the child care and contributes to female subordination. In a similar way Schmied and Lupton’s (2001) interviews with first-time mothers reveals a variety of contradictions including tensions between a romanticized notion of bonding through breastfeeding and the physical displeasure and/or loss of independence in its embodiment.

Together Avishai’s work with privileged (well educated, middle class) mothers and Marshall’s (2011; Marshall, Godfrey, & Renfrew, 2007) work with midwives and postpartum mothers demonstrate how mothers manage these aforementioned

contradictions. Avishai (2007) details the approach privileged mothers took to breastfeeding – project. Using the project metaphor, mothers talked about breastfeeding as a motherhood project as a way to manage the lactating body, feeding schedules, milk production, and planning. The women in Marshal, Godfrey, and Renfew’s (2007) study had access to midwives, lactation consultants, and other medical professions postpartum to facilitate infant feeding knowledges and practices. The women in this study openly talked about the *Breast is Best* message’s prevalence and the social pressures to breastfeed to be a good mother. However, they managed the contradictions and judgments associated with breastfeeding by adapting their identities to their embodied experiences. For example, when the women were unable or chose not to breastfeed, they would emphasize a different aspect of mothering.

Scholarship from disciplines in the social sciences and humanities including English, Sociology, Political Science, History, Anthropology, and Communication has generated increasing interest in pediatric nutrition from critical perspectives. Nevertheless, the focus within this body of research has been almost exclusively on motherhood and breastfeeding, leaving the wider context of families and other caregivers as well as other stages of pediatric nutrition in the recesses of research design and exploration. It is the intent of this project to extend the work on pediatric nutrition by examining both mothering and fathering (parenting) and examining nutritional advice from birth through one year.

Conclusion and Preview of Chapters

A significant component to a baby's health is marked by his or her weight gain. Thus, nutrition is a vital concern to parents during the first year of their children's lives. During the time women and men take to apprehend their roles as mothers and fathers, they must make an array of choices regarding their children's health. Such choices center on formula, human milk, bottle-feeding, breast pumping, fruit juices, cereal, processed baby food, organic baby food, and homemade baby food. Given the influence child feeding discourses have on parents' choices and perception of responsibility (Lee, 2007; Wolf, 2007a; 2011), this study seeks to unpack the messages that constitute good parenting. In sum, this study extends parenting and pediatric nutrition research to 1) fill in gaps on fathering, 2) explain inequitable distribution of child care in the division of household labor, 3) integrate research on breastfeeding and formula feeding with the introduction of solid foods, and 4) critically examine pediatric nutritional instruction.

This study is organized into a preface and six chapters. Chapter I introduces the three primary research questions and literatures on parenting and pediatric nutrition that frame this study. More precisely, Chapter I establishes a rationale and framework for studying pediatric nutrition birth through the first year in order to make connections between this set of discourse and issues related to gender, family, and health communication. Chapter II explains the methods used to collect and analyze the pediatric nutrition instructional materials that target parents during the first year of their children's lives. The methods used to identify articles in *Parenting* and *parenting.com*, which are the primary data sources, are clarified. Additionally, secondary data sources

are identified within this chapter. The remainder of Chapter II is devoted to explaining narrative inquiry, narrative research in health, and master narrative analysis.

Chapters III and IV are the findings chapters. Chapter III constructs a master narrative of pediatric nutrition labeled *moderate naturalism* by examining messages about the plot of good parenting and feeding practices that cohere across instructional texts. Particular attention is given to the essential elements of narrative including plot, chronology, character development, motivation of characters' feeding choices, and baby feeding scenes. Chapter IV also attends to essential elements of narrative but does so in relation to alternative narrative constructions of pediatric nutrition. These counter or alternative narratives are compared and contrasted with the master narrative and exhibit permeable plot boundaries, thus, permitting parents to shift between narratives depending on scene, context, complication to plot, and motivation. Labeled *synthetic acceptance* and *strict naturalism*, the two counter narratives are constructed oppositionally in terms of the degree of naturalness adopted in their prescribed practices. *Synthetic acceptance* counters the master narrative constructions of good mothering defined by breastfeeding and proposes alternative actions to accomplish the aims of totalizing motherhood. *Strict naturalism* counters the master narrative constructions of good mothering by politicizing the role of mothers and adopting natural practices in both breastfeeding and the introduction of solid food stages.

Following the two chapters that elucidate master and counter narratives, Chapter V teases out the implications of these narratives in regard to authority. Despite certain characters that retain their authority across the pediatric nutrition narratives, each

narrative characterizes and emphasizes sets of authority figures differently.

Furthermore, Chapter V argues that authority is attributed to both characters within the narration as well as the texts themselves. Thus, pediatric nutrition narratives have certain texts that have more authority over what constitutes good or bad parenting within the narrative. While the implications of pediatric nutritional messages are important for health communication researchers to explore, the utility of this study is further evidenced in Chapter VI's recommendations to various characters within pediatric nutrition narration that have the responsibility to transform it. Chapter VI concludes this study by summarizing the master and counter narratives, contributions of the study, research limitations, and directions for further inquiry.

CHAPTER II

METHODS FOR COLLECTING AND ANALYZING TEXTS

My exposure to pediatric nutritional advice began with the pregnancy of my first son. The initial visit to the OBGYN was marked with excitement and trepidation. I was entering into the unknown of pregnancy and parenthood. Hearing the heartbeat on the internal sonogram was one of the first tangible evidences of the transition to parenthood (quickly followed by poorly termed *morning sickness*). The rapid thumping coming through the medical equipment and dot on the screen was my child. The image and sound spurred a romanticized notion of parent-child bonding and increased my enthusiasm for motherhood. What followed the “exam” jolted me back into the realities of parenthood as the physician handed me a stack of reading material on pregnancy, labor and delivery, and breastfeeding. I felt like I had signed up for a seminar on reproduction and infant care. What had I gotten myself into? On my way out with books and pamphlets in tow, I added *Parenting* magazine to my reading list. The credenza by the office exit was lined with the two most recent issues of *Parenting* in English and Spanish for patients to take with them. Free and relevant hooked me, and I left with my first copies of *Parenting*.

Retrospectively, this introduction to pediatric nutrition texts is what sparked my personal interest into the ways in which instructional messages about child feeding construct gender roles in the family and contribute to the development of food and eating patterns for the family. Through personal experiences, I began to see how powerful these messages were in my own constructions of good mothering and feeding. In several

ways stepping out into the unknowns of motherhood is similar to studying pediatric nutrition instructional materials that so heavily influence motherhood. While good instruction and resources can help guide both mothering and scholarly inquiry, there are inevitable twists and turns along the way that require a degree of improvisation. The following section uses Janesick's (2000) description of qualitative and interpretive inquiry in terms of the dance metaphor to highlight the need for improvisation in the roles of both mother and researcher.

Choreography and Improvisation: A Metaphor for Mother and Researcher

The metaphor of dance can be quite utilitarian in explaining two roles relevant to this study: 1) mother and 2) researcher. Let me begin this section by clarifying what is meant by choreographed and improvisational dance harkening to Janesick's (2000) rich discussion of dance and research. To better grasp what is implied by the term "choreography," consider a very traditional form of dance, ballet. Ballet instructors teach their pupils basic positions and moves including arabesque, assemblé, balancé, chassé, plié, pirouette, and tendu. Choreographers combine these positions and moves in unique ways to comprise a dance that is taught and performed to an audience. Choreography is pre-designated by the choreographer, who maintains creative control over the dance and carefully plans and teaches the dance in accordance with his(her) intentions. Improvisation, on the other hand, is much more spontaneous. In my experience with modern dance in a university dance company, improvisation permitted adaptation of learned movement, creative construction of new movements, and spontaneity. Improvisation is not the absence of order nor is it the absence of form and

technique. Instead, improvisation frees the dancer to select and combine moves during the performance in ways that choreography does not. For example, my dance company was commissioned to perform at our campus “Work Day.” Portions of the dance were improvisations under the direction of the “theme” work. While we mimicked movements of manual labor, we also integrated these movements within techniques and moves learned as a part of our training. Thus, improvisation depends on the structure, form, and technique utilized in choreographed dance but permits freedom in how these moves are interpreted and combined. With this understanding, my experiences as an expectant first-time mother and as a researcher embody the tensions between choreographed plans and improvisational freedom.

As a first-time expectant mother, I learned from instructional texts, like those given to me by the obstetrician and the *Parenting* magazines I picked up in his office. These texts contained a nutritional design set out for me to study and implement preferred feeding practices. I anticipated a choreographed feeding routine from my readings: wake baby, breastfeed for 10 minutes per breast, entertain and bond with baby, put baby down for nap, and begin the process all over again every two hours. In the texts, I learned feeding technique and form like the football breastfeeding hold, the one-arm burp, and how to document feeding schedules and daily outputs. Be that as it may, my anticipated choreographed dance became much more improvisational after the birth of my son. When my son did not want to eat after two hours, I improvised and tried again 30 minutes later to feed him. When he wanted to go right back to sleep after nursing, I obliged. When my breasts were engorged and he struggled to latch, I pumped

and fed him from a medicine dropper and a bottle in the first week. I was using all the technique, positions, and practices that I had learned through studying instructional materials during pregnancy, but I was improvising through spontaneous adaptation and creative exploration of what worked for my family. The tension between choreography and improvisation was at its height when I felt low levels of efficacy as a new mother and when the choreography did not fit the needs of the situation. As I began to select which sets of feeding instruction were most applicable to my family and venture from choreography, I gained confidence in my ability to improvise and to mother.

In addition to the dance metaphor helping to explain my relationship as mother to the instructional texts that shaped my expectations of feeding, the dance metaphor is also useful in explaining my relationship as researcher to the process of designing and conducting qualitative inquiry. In fact, Janesick (2000) artfully likens qualitative methods to dance. The forethought of research design and systematic application of methods is invoked in the dance metaphor in the ways in which a choreographer determines the moves, rhythms, and sequence of a dance. In many ways, this chapter is aimed at revealing how I both planned and executed the choreographic design of qualitative research. However, the metaphor of dance also invokes a sense of flexibility and elasticity, especially in reference to improvisational performances. I have applied the improvisational spirit of the dance metaphor by refining the research questions and how I categorize the data. I have experienced the tensions between these two invocations of dance during this project. In the design of this study, my choreography was heavily influenced by my teachers and the narrative, health communication, and

gender readings that I was exposed to through my education. The specific moves, rhythms, and sequencing I set into motion focused on collecting pediatric instructional texts, reading through the texts to identify narrative components and themes, and constructing narrative plots from the texts. Originally, I had embarked on this study planning to compare and contrast how various sources of pediatric nutrition approached instruction differently or constructed different nutrition narratives. Within this train of thought, I had included the research question, “How do different types of pediatric instructional texts narrate nutrition similarly and differently?” However, during initial coding of the data, I quickly realized that language choice and message content were similar across texts (with a few notable exceptions including the Organic Baby Resource website and Moms Feeding Freedom blog). This research question is no longer a focal point of my research. Just as improvisation became quintessential to adapting my feeding practices as mother, I have experienced the value of improvisation while collecting and analyzing the textual materials in this study.

My personal narratives with choreographed and improvisational mothering and researching frame my discussion of collecting and analyzing textual materials. In terms of selecting and collecting textual materials, my story highlights the texts that I was first introduced to in my obstetrician’s office, which shaped my expectations and subsequent improvisations as mother. In terms of textual analysis, my research narrative emphasizes the narrative framework that not only informs my understanding of human communication and writing but also my methods for analyzing data. Indeed, it is evident that a narrative framework is already assumed in the writing of this study and will be

made more apparent in the following sections as I contextualize this study within health communication scholarship, the narrative paradigm, and the specific narrative methods applied.

Narrative and Health Communication

Health communication's status as a field of study gained momentum in 1972 with the establishment of the Therapeutic Interest group in the National Communication Association later becoming the Division of Health Communication in 1975 within the International Communication Association (Dutta & Zoller, 2008; Sharf, 1993). Interested in patient-physician and clinical contexts, social support, and public health information and campaigning, pioneering scholars set the stage for field-specific journals (e.g. *Health Communication* and *Journal of Health Communication*) and handbooks (e.g. editions of the *Handbook of Health Communication* in 2003 and 2011) that define the scope of inquiry categorized as health communication. As the field has grown, so has research with a narrative bent (e.g. see Harter, Japp, & Beck, 2005, an edited volume on narrative and health, "Defining Moments" section of *Health Communication*, and the special issue of the 2009 *Journal of Applied Communication Research* on health as narrative). Narrative and health scholarship converge on a wide range of health concerns and contexts providing insight into topics such as physician-patient interaction and narrative medicine (Charon, 2005; 2006; DasGupta & Charon, 2004; Sharf, 1990; Sharf & Vanderford, 2003); family communication (Aleman & Helfrich, 2010; Anderson & Geist Martin, 2003); public health interventions (Petraglia, 2007); physical therapy (Mattingly, 1998); social support and community (Adelman & Frey, 2001);

teamwork and backstage organizational communication (Ellingson, 2005); gender (Barnett, 2005); illness/health narratives (Bingley, Thomas, Brown, Reeve, & Payne, 2008; Frank, 1991, 1995; Titus & de Souza, 2011); illness legitimacy (Barnett, 2005; Japp & Japp, 2005); discourse, power, and culture (Dubriwny, 2009; Harter & Japp, 2001; Japp & Japp, 2005; Shugart, 2011); health decision making (Ellis & Bochner, 1993); and media transportation and health beliefs/behaviors (Green, 2006). These scholars have employed a variety of qualitative methods to collect narrative data including autoethnography (e.g. Adelman & Frey, 2001; Ellis & Bochner, 1992; Frank, 1991, 1995), participant observation (e.g. Ellingson, 2005; Aldeman & Frey, 2001), interviewing (e.g. Anderson & Geist Martin, 2003; Sharf, 1990), participants' written accounts (e.g. Titus & de Souza, 2011), photography (e.g. Sharf, Harter, Yamasaki, & Haidet, 2011; Yamasaki, Sharf, & Harter, in press), and mediated texts and images (e.g. Barnett, 2005; Dubriwny, 2009; Green, 2006; Kenny, 2001; Shugart, 2011).

While narrative health communication scholars have wide ranging interests in health issues from cancer to obesity, their works have contributed to the understanding of intersections between health and narrative. Importantly, this vein of scholarship is undergirded by a social constructionist approach to health communication (Sharf & Vanderford, 2003). That is to say, narrative health communication research has furthered inquiry into the ways in which health is constructed in and through storied communication. Narrative health communication studies assert that knowledge exceeds the scope of scientific, objective, biomedically substantiation to encompass people's embodied, socially situated experiences (Beck, 2001; Sharf & Vanderford, 2003).

Stories become communicative vehicles (Ragan, Wittenberg-Lyles, Goldsmith, & Sanchez-Reilly, 2008) for co-constructing meaning and making sense of health, exploring uncertainties, (re)constructing identities and expressing oneself, warranting health decisions, and building community (Sharf et al., 2011; Sharf & Vanderford, 2003). For example, Arthur Frank's (1991, 1995) work with illness storytelling provides insight into story types – restitution, chaos, and quest - and how storytelling functions for the storyteller and audiences. Frank argues that illness storytelling is embodied and results in witnessing to others through the storytelling process in ways that can help others cope and give voice to experience. In another example, Yamasaki's (2010) narrative research with Prairie Meadows Senior Living, a managed care facility in the Midwest US, utilizes photovoice as means of encouraging seniors to express their stories from their perspectives. Yamasaki draws attention to one participant's rich story that ebbs and flows between control and loss of control and, ultimately, communicates a survivor identity achieved through narrative possibility and familial/community social support.

Meanings not only encompass individuals' experiences but also encompass cultural, social, and political discourses about health. Narrative health communication research focusing on health discourses, more broadly, include Dubriwny's (2009) work with "survivorship" and the breast cancer patient, Japp and Japp's (2005) work with biomedically invisible diseases and legitimacy, Harter and Japp's (2001) study of technology in health dramas, and Shugart's (2011) examination of shifts in obesity narration in reality TV. These larger health discourses are termed master or

metanarratives, which will be discussed in more depth in a later section. Japp and Japp (2005) describe how individuals with biomedically invisible diseases lack narrative legitimacy because the master narrative of medicine values scientifically substantiated diseases. Through resistance storytelling, people with biomedically invisible diseases seek legitimacy and take their storytelling public in order to transform the master narrative. Whether the focus is on illness storytelling in the family, narrative medicine in the clinic, or master narratives of obesity in society, narrative health communication scholars are ultimately interested in storied communication and how it shapes the meaning of health. To further elucidate narrative health communication literature and situate this study within the literature, the following sections review the narrative paradigm that has influenced narrative health communication scholars, the narrative focus assumed in this study, and the specific method of narrative analysis that complements it.

Narrative Framework

A narrative framework assumes that humans communicate and interpret experience and meanings through storytelling processes. In Walter Fisher's resounding words, we are *homo narrans*. But, what is meant by narrative and story is difficult to solidify in the narrative paradigm, which encompasses multi-disciplinary research from social sciences and humanities. The focus of this section is to: ground this study within the narrative paradigm, demonstrate how pediatric nutrition instruction fits Fisher's narrative rationality, elucidate what is meant by the term narrative, and demonstrate the

utility of narrative in studying texts about health, specifically pediatric nutrition instruction and parenting.

Narrative Rationality

Walter Fisher (1984, 1987) explains the narrative paradigm in terms of what it is and what it is not by juxtaposing the narrative paradigm with the rational world paradigm. The rational world paradigm assumes that humans are rational decision makers that draw upon situation-specific structures for logical argumentation. Therefore, human communication is centered on rule-bound, expert arguments, which circulate in a public sphere using a common language for an audience. To engage in the rational world, humans are socialized into the logical structures of science – natural and human sciences. In turn, naturalism and a focus on science has diminished the public value of argumentation and led to reformations in argumentation noted by Fisher. Rather than furthering the reformation of the rational world paradigm, Fisher introduces the narrative paradigm as an alternate explanation for human communication.

The narrative paradigm assumes that humans are storytellers that draw upon good reasons to make decisions and determine the rationality of good reasons by assessing narrative probability and narrative fidelity (Fisher, 1984, 1987). Narrative probability and fidelity “contrast with but do not contradict the constituents of rationality” (Fisher, 1984, p. 9). Rationality is learned through education, requires self-conscious analysis, and produces certainty; whereas, narrative rationality is more obvious, not requiring specialized education to use and understand, and is composed of

moral arguments. With a distinct focus on public moral arguments, Fisher defines these as follows:

The features differentiating *public* moral arguments from such encounters are: (1) it is publicized, made available for wide consumption and persuasion of the polity at large; and (2) it is aimed at what Aristotle called “untrained thinkers,” or, to be effective, it should be. Most important *public* moral argument is a form of controversy that inherently crosses professional fields. It is not contained, in the way that legal, scientific, or theological arguments are, by their subject matter, particular conceptions of argumentative competence, and well-recognized rules of advocacy... *Public* moral argument, which is oriented toward what ought to be, is often undermined by the “truth” that prevails at the moment. The presence of “experts” in *public* moral arguments makes it difficult, if not impossible, for the public of “untrained thinkers” to win an argument or even to judge arguments well... (1987, p. 71).

Therefore, narrative rationality is expressed in public moral arguments that are persuasive, targeted at the widespread public, and intended for “untrained” or non-expert audiences.

Considering Walter Fisher’s articulation of the narrative paradigm, the aforementioned body of health communication research fits within the scope of the narrative paradigm. Illness storytelling and narrative medicine research assumes a narrative rationality and takes on storied forms of expression, usually in interpersonal, familial, and/or organizational relational contexts. Master or meta-narratives may or

may not present themselves in storied form, but the researcher is able to construct a narrative from various publically circulated texts on the subject and demonstrate the power of the constructed narrative. Both Dubriwny (2009) and Shugart (2011) work with narratives in order to construct master narratives – Dubriwny’s work with Betty Ford’s survivorship narrative and Shugart’s work with dramatized obesity stories in reality television. In a different fashion, Japp and Japp (2005) use author Laura Hildenbrand’s illness story to demonstrate how resistance storytelling can generate a legitimacy narrative in opposition to the master narrative, specifically her story of living with Chronic Fatigue Syndrome and how it builds legitimacy for biomedically invisible diseases. In relation to the research represented in this study, the question remains as to the narrativity of pediatric nutrition instruction. On one end of the spectrum, pediatric nutrition instruction is unequivocally narrative in nature. Arguably one of the primary advice genres is story. *Parenting* articles and other instructional texts are replete with stories that recount mothers’ experiences with engorged breasts, breast pumping at work, picky eaters, and the like. At the other end of the spectrum, pediatric nutrition instruction takes the form of 1) “how to” manuals and 2) medical research on nutrition and feeding practices. More often than not, the “how to” and medical research advice is interspersed with nutrition and feeding stories. When constructing a master narrative, one question to ask may be related to the recounting of stories, but Fisher (1984, 1987) also discusses stories that account for or explain good reasons. In terms of master narratives, another way to determine the narrativity of the texts being used may to ask if the texts construct an account. This study argues that pediatric nutritional texts create a storied account for

good parenting by outlining characters' roles, plot, action, sequence, value, and motivations.

At this juncture, another relevant question arises as to the appropriateness of the narrative paradigm to the study of pediatric nutrition instruction. Does pediatric nutrition instruction constitute a public moral argument? Arguably, the answer would be “no” if the question was slightly altered to ask, “Does pediatric nutrition research constitute a public moral argument?” Pediatric nutrition research is conducted using the scientific method by medical researchers and practitioners (e.g. pediatricians and lactation consultants). This type of research is circulated amongst the medical community, not for widespread consumption. But, the subject of analysis is not pediatric nutrition research; the subject is pediatric nutrition instruction, which is oriented toward “untrained thinkers” even as experts contribute to the instruction. Another important question to ask related to the applicability of the narrative paradigm to pediatric nutrition instruction is, “Does pediatric nutrition instruction utilize narrative rationality?” To determine the quality of narrative rationality presented in public moral arguments, audiences consider narrative probability (e.g. Does the story make sense? Are characters and actions consistent?) and fidelity (e.g. How does the story resonate with listeners' everyday lives?). Narrative rationality will be explored more thoroughly in analysis Chapters III, IV, and V in terms of how master and alternative narratives of pediatric nutrition instruction are coherently constructed and various degrees of fidelity that they may have with parents. For example, in Chapter IV discussion of the alternative narrative entitled “strict naturalism” focuses on the fidelity of its

characterization, plot, and actions with parents who are motivated by eco-friendly, organic lifestyles overall, not just in relation to nourishing their baby.

Narrative Components

As narrative scholars approach data with narrative sensibilities, they attend to particular narrative components. Yamasaki, Sharf, and Harter (in press) identify plot, characters, motives, time or chronology, values and life lessons, scene, context, and storytelling as essential narrative components. Narrative is set in motion by a rupture, or peripeteia (Bruner, 2002), in the mundane, everyday experience that transforms the commonplace. Thus, *plot* “is a series of events leading to a tensional situation needing to be resolved” (Sharf, in press) and described as the “life blood of a narrative” (Riessman, 2008, p. 4). Pregnancy functions as peripeteia in a woman’s life as she becomes physically and symbolically marked as mother by her protruding uterus (Buzzanell & Ellingson, 2005). The large midriff dissipates post-partum (albeit at differing rates), but the introduction of a new child into her and the other parental figure’s lives remains. With each new developmental stage coinciding with pediatric nutrition, parents face ruptures that shift plot, introduce new characters, and demand different sets of specialized knowledge. Motherhood and fatherhood are living, parental identities (Miller, 2005) that need to be studied in conjunction with plot progressions, complications, and resolutions. Inextricably linked to plot are *temporal considerations* of sequencing and chronology of events, the implications of temporal orientations to possible resolutions, and the ways in which characters use time. Timing for pediatric

nutritional narratives highlights parental choices and responsibilities that progress alongside the biological development of a child.

Characters, then, are the actors, either beings or matter, that affect and are affected by plot progression (Sharf, in press; Yamasaki, et al., in press). Mothers and fathers are featured characters in pediatric nutritional narratives because of role expectations related to dependent care. Nevertheless, parents are not the only characters implicated by plot. By focusing on characters, narrative inquiry may better understand how social actors like peers or medical professionals are represented in mediated messages about pediatric nutrition, how parents are instructed to communicate with child care workers about pediatric nutrition, or how pediatric nutritional texts become characters within the plot. Furthermore, a “close reading” (Charon, 2006) of characterization affords insight as to which characters have authority to shape plot and influence other characters and the *motivations* of characters that explain the why’s of their choices and actions (Sharf, in press).

Characters act and plot progresses in various scenes. The scene provides a backdrop, locale, or environment for interaction to unfold (Sharf, in press). Research on breastfeeding had already identified differences between public and private scenes. Whereas breastfeeding in the privacy of a home is both normalized and idealized, breastfeeding in public places like a restaurant or retail store is eroticized and contentious (Blum, 1999; Hausman, 2003; Rose, 2012). Pediatric instructional messages extend beyond breastfeeding, but how do such messages address scene and how may scene constrain or enable the advised plot progression? For example, parents, who make

their own baby food with home grown organic fruits and vegetables when they are at home, may have difficulty adhering to preparation and storage instruction when the scene changes during family travel. Differences in scene are important to note, especially in relationship with how scene may affect parental efficacy to adhere to pediatric nutrition recommendations. Not to be confused with scene, *context* subsumes the overarching circumstances, in which the narrative unfolds and is communicated. In the case of pediatric nutrition, contextual features include parenting discourses (i.e. roles of mothering and fathering), socio-economic class (i.e. access to resources to implement nutritional instruction), and social and political structures (i.e. maternity and paternity leave policies).

Notable hallmarks of the communication process are its generativity and consequentiality. In other words, narratives do something. Riessman (2008) describes common narrative functions to recall, argue, persuade, engage, entertain, mislead, and mobilize. In the context of health communication, Sharf and colleagues have surmised that narratives function to make sense of health experiences, assert control over health, transform identity challenged by health conditions, facilitate and warrant decision making, and build community (Sharf & Vanderford, 2003; Sharf, Harter, Yamasaki, & Haidet, 2011). The overall consequentiality of the narrative and the ethical implications of resolution are what are described as *values, morals of the story, and life lessons*. The *values* of pediatric nutrition narratives in relation to power, gender, and parenting are important directions for analysis. Finally, narrative scholars agree that *storytelling* is an essential consideration in the study of narrative. Storytelling alludes to stylistic features

of the narrative, the process of communicating a narrative to a particular audience, and the effectiveness of storytelling to achieve the storyteller's goals (Yamasaki et al., in press). Attention to storytelling and the aforementioned narrative components should direct narrative analysis to narrative rationality, specifically probability and fidelity (Fisher, 1984, 1987). Such questions as, "How does pediatric nutrition instruction construct parenting plots?" and "Why may a particular parenting plot ring true with some parents but not others?" guide analysis toward answers related to narrative probability and fidelity. With a working knowledge as to what features are more or less the composition of narratives and focus of analysis, this chapter proceeds into a discussion of the particular texts used to construct and analyze pediatric nutrition narratives.

Pediatric Nutrition Instructional Texts

There are a wide variety of sources of information on child feeding from birth through year one. Such sources include: 1) interpersonal relationships with friends, family, coworkers, and community members (see Bobel, 2001; Cripe, 2008 and Koerber et al., 2012), 2) interpersonal relationships in clinical contexts with medical professionals (see Koerber, 2006 and Marshall et al., 2007), and 3) mediated information in a variety of formats including magazine articles, books, pamphlets, brochures, blogs, Internet sites, and social media (see Wolf, 2011 for analysis of advertising and published medical research; Hausman, 2003 for analysis of advertising and books; and Murphy, 1999 and 2003 for analysis of policy and governmental sponsored advocacy). The scope of this narrative health communication study is limited to written pediatric instructional

messages, also referred to as texts. For a quick look at the texts included in this study, see Appendix A entitled Pediatric Nutrition Instructional Texts.

The primary set of texts for this study is *Parenting* magazine articles and the companion website. *Parenting*, a monthly magazine, is the flagship publication of the Parenting Group, a subsidiary of Bonnier Corporation (Dobrow, Oct. 2010). The Parenting Group publishes four distinctive magazines – *Parenting*, *Babytalk*, *Conceive*, and *Working Mother*, of which, *Parenting* has the largest circulation rate at 2.15 million and an estimated audience of 10 million² (Bonnier Corporation, 2011). Due to its popularity, the Parenting Group expanded the reach and scope of *Parenting* by publishing two age-specific magazines entitled *Parenting Early Years* and *Parenting School Years*. Compared to its leading rival *Parents* magazine, *Parenting* has a slightly larger verified subscription rate, which helped in selecting between the two magazines to be included in the data set (Audit Bureau of Circulations, 2010). In 2011 *Parenting* was ranked 23rd in the US based on circulation rates and was the only magazine focused on parenting to be ranked in the top 25 US magazines (Pew Research Center’s Project for Excellence in Journalism as cited in Matsa, Sasseen, & Mitchell, 2012). The use of magazines like *Parenting* is consistent with Foss’ (2010; Foss & Southwell, 2006) longitudinal content analysis of breastfeeding messages and construction of motherhood in *Parents Magazine* and with Ferich and colleagues (Ferichs, Andsager, Campo, Aquilino, & Steward, 2006) framing analysis of infant feeding across a spectrum of U.S.

² Circulation rates measure the number of printed magazines in subscription and sold. Estimated audience rates assume that a single magazine is viewed by multiple people. In the case of *Parenting*, magazine subscriptions are held by businesses, like the doctor’s office where I was first introduced to the magazine, which exposes one magazine to multiple people.

magazines. While these studies focus solely on breastfeeding/formula-feeding, they argue for increased attention to popular media, like parenting magazines, in the study of pediatric nutrition, which is the aim of this study and logic behind the set of textual materials selected for analysis.

To collect articles from *Parenting*, I used a database accessible through the Texas A & M University Library. Using EBSCOhost database, I searched through *Parenting* magazine articles published between 1996 and 2008 and *Parenting the Early Years* magazine articles published between 2009 and 2012³. Thus, the time span for the study is 16 years. I used the following search terms to retrieve relevant print articles: infant feeding, solid foods, baby food, breastfeeding, and formula. These search terms were generated by surveying several issues of *Parenting* and its companion website to determine the language used within the magazine to refer to pediatric nutrition issues from birth through 12 months. Terms like “nutrition,” “allergies,” and “vitamins,” to mention a few, were topics often subsumed within infant feeding, solid foods, baby food, breastfeeding, and formula. The search resulted in 19 articles referencing infant feeding, 20 articles referencing solid foods, 69 articles referencing baby food, 114 articles referencing breastfeeding, and 25 articles referencing formula. Because an article may reference multiple topics/terms related to pediatric nutrition, I refined the data set by removing duplicate articles. I further refined the data set by removing articles that

³ The data range for this study is influenced by two factors. First, I aimed to collect data between a 15 and 20-year range to provide a sufficient pool of articles to read and analyze. I was concerned that a smaller range of dates may limit the number of articles that could be analyzed and effect the types of conclusions that could be drawn. The aim of this study is not to track trends over time on a timeline, although suggestions of trends in the data are noted in analysis. Second, the specific 16-year time span, rather than a multiple of five, is due to the accessibility of articles through the database employed for the study.

referred to the search terms, but did not place the terms as the central focus of the article. All in all, approximately 150 print articles were read and analyzed during the coding process.

To collect web-based data from www.parenting.com, the companion website for *Parenting*, I used the featured articles in the section “feeding” under the *baby* tab. There were 80 articles available in the “feeding” section covering a range of topics including breastfeeding, formula feeding, bottle-feeding, milk storage, preparing bottles and food, introducing juice and solid foods, avoiding risky feeding practices, and informing parents about popular culture and feeding. Because some baby feeding instruction on www.parenting.com is completely web-based and some is reposted from the print magazine, there is some overlap in the website and magazine. If the articles were originally printed in *Parenting*, I used and cited the printed article rather than the web-based version. As topics arose in the print and web-based articles, I used the search function on *Parenting*'s website to gather additional articles as needed. For each article, *Parenting* provides a comments section where readers can post opinions and post questions. For each article reviewed I read the posted comments and included the comments in the analysis when deemed relevant. However, readers did not comment on all articles. Additionally, I perused the *mom* and *dad* tabs for links to articles on pediatric nutrition, but there were none posted at the time of data collection.

The secondary set of texts, which will be identified later, were used to help tease out narrative components either presented or silenced within the primary set of texts. Secondary texts were helpful in expounding upon narrative components identified in the

primary texts. For example, *Parenting* identifies mutual benefits of breastfeeding in a wide variety of articles, print and web-based, but I found that secondary texts, especially manual-like books, to be helpful in providing fuller explanations as to the benefits. Secondary texts were also helpful in filling out gaps and silences in the primary texts. For example, narrative elements of the alternative narrative entitled “strict naturalism” are present in *Parenting*, especially web-based articles and blogs, but teasing out this narrative in terms of its intertextuality – how the narrative intersects with and draws upon other societal discourses – required secondary texts.

To collect supplementary texts, I sought a variety of pediatric nutrition instructional sources. First, I reviewed books that broadly approached infant care with sections on feeding or targeted specific feeding practices. Using the Amazon.com website and my personal library, I collected books that were the top books on Amazon based on the following searches: infant care, baby food, and homemade baby food. The books analyzed include: 1) *On Becoming Baby Wise: Giving Your Infant the GIFT of Nighttime Sleep* (Ezzo & Bucknam, 2012), 2) *Mayo Clinic Guide to Your Baby’s First Year* (Cook, Johnson, & Krych, 2012), 3) *The Baby and Toddler Cookbook: Fresh, Homemade Foods for a Healthy Start* (Ansel & Ferreira, 2011), 4) *The Baby Book: Everything You Need to Know about Your Baby from Birth to Age Two* (revised edition) (Sears, Sears, Sears, & Sears, 2013), 5) *The Baby Food Bible: A Complete Guide to Feeding Your Child, from Infancy on* (Behan, 2008), 6) *The Best Homemade Baby Food on the Planet* (Knight & Ruggiero, 2010), 7) *What to Expect the First Year* (Murkoff &

Mazel, 2010), 8) *Your Baby's First Year* (3rd edition) (Shelov, 2010), and 9) *Your Pregnancy Week by Week* (5th edition) (Curtis & Schuler, 2004).

Second, I incorporated booklets given to me by medical professionals while pregnant with my first son. While two of the three booklets are general infant care texts, significant portions of the booklets are devoted to feeding instruction. The booklets include: 1) *A Miracle in the Making* (Hayman, 2002), 2) *The Physician's Pocket Guide to Breastfeeding* (Texas Department of State Health Services, 2001), and 3) *Your Life After the Baby is Born: The Post Partum Period* (Neimark, 2001). Third, I downloaded the pamphlets and brochures from the US Department of Agriculture's Food and Nutrition Service that houses the Women, Infants, and Children (WIC) program. These materials can be ordered in bulk or downloaded to print directly from the website and represent the official voice of WIC to its clients regarding infant feeding. Seven of the brochures are a continuation of the 1996 Breastfeeding Awareness campaign and the eighth brochure is a 2011 publication of The Joint Commission. The Joint Commission is an independent, not-for-profit organization that accredits and certifies US health care organizations and programs and publishes a series of "Speak Up" messages targeted to patients in order to encourage them to take an active role in their care (The Joint Commission, 2013). These texts are short, feature photographs, and are available in English and Spanish. Fourth, three different baby resource websites were identified by googling "baby resource website." The Baby Center (2012) and Baby Zone (Disney, 2012) are websites that contain subject indexed baby care information in the form of

articles, blogs, and peer-to-peer virtual communities. Additionally, these websites have either direct product links on the website and/or are retailers for baby care products.

Finally, the Moms Feeding Freedom blog, the Fearless Formula Feeder blog, the Honest Baby blog, and the 100% Natural Parenting blog are included as a supplementary texts, that are especially helpful in analyzing counter narratives. The Moms Feeding Freedom blog has three primary contributors: Kate Kahn (journalist and editor), Barbara Dehn (women's health nurse practitioner and founder of a publishing company for women's health information), and Jennifer Sillman (health communication specialist). All three contributors hold master's level degrees in either journalism or nursing. Blog posts, readers' comments, and readers' stories range from 2007 through 2012. The aim of the blog, as evidenced in their tag line, is to help "parents nurture healthy babies." To accomplish this aim, the blog addresses contemporary breastfeeding and formula feeding concerns, medical research, culture, and feeding support. The Fearless Formula Feeder blog by Susan Barston assumes a storytelling format as maternal feeding stories comprise the majority of blog content. The Honest Baby blog is a blog associated with a company that sells environmentally-friendly and organic products, and in a similar genre, the 1000% Natural Parenting blog by Taylor Newman is a blog focused on natural living sponsored by *Parenting* magazine's companion website. Books/Manuals, booklets, pamphlets, brochures, resource websites, and specialized blogs provided supplemental support. The final section of Chapter II introduces the specific narrative method employed to analyze the primary and secondary sets of texts.

Studying Master Narratives

When Fisher (1984, 1987) published his treatise on the narrative paradigm, he was quick to distinguish the narrative paradigm from a method of narrative analysis. Rather than a singular method of analysis, the narrative paradigm hosts a plurality of methods⁴ used to analyze different narrative forms and contexts. The following section outlines the type of narrative analysis applied to pediatric nutrition instruction – critical rhetorical analysis of master and alternative/counter narratives. The overarching goal of a critical approach to health communication is

to understand the communicative processes and meaning constructions in the realm of power, thus exploring the ways in which communication is constituted within structural realms, and the processes through which the discursive constructions of health reflect and reinforce dominant power structures” (Dutta & Zoller, 2008, p. 13).

Examining master and counter narratives is an examination of the “discursive constructions of health” to better understand how power structures are (re)produced and transformed through narrative. To begin, the focus is on defining and understanding how master narratives are constructed and function within public discourse. Next, the focus turns to defining and understanding counter or alternative narratives and their

⁴ Within the Narrative Paradigm exists a family of narrative methods used to analyze a variety of narrative data. Methods include fantasy theme analysis, pentadic criticism, thematic analysis, structural analysis, dialogic/performance analysis, visual analysis, discourse analysis, and critical rhetorical analysis (Barthes & Duisit, 1975; Bormann, 1985; Burke, 1945 ;Mumby, 1993; Riessman, 2008; Shugart, 2011).

relationship to master narratives. Finally, the process for applying this type of narrative method to pediatric nutrition instruction is discussed.

Master/counter Narratives and Power

Master/counter narrative analysis is a specific method of applying critical analysis to a narrative discourse threaded through society (Shugart, 2011). This narrative method seeks to understand and critique the dominant, or master, narratives embedded in social contexts. Bergen (2010) explains that “master narratives reflect the values of the dominant culture and set the standards for normative behavior in relationships, providing a template for determining (un)acceptable behavior” (p. 47). That being so, the master narrative directs action by defining acceptable and unacceptable behaviors in association with the values expressed through the narrative and silencing alternative narrative formations (Bergen, 2010; Bosticco & Thompson, 2008; Mumby, 1987). Identifying and explaining what discourse constitutes the master narrative, master narrative analysis seeks to understand how such discourse functions powerfully. Questions arise as to whose interests are served in the master narrative, whose voices are silenced within the narrative, what meanings are privileged versus marginalized, and what are the social, political, cultural, and material consequences of the narrative. The literature in this area provides illustrative master narratives, and one such example master narrative can be found in Yu’s (2010) analysis of Tibetan narrative in US culture. Yu argues that Americans view Tibet and its struggle with China through the cultural lens of democracy resulting in a master Tibetan narrative that features freedom, peace, and spiritual authority as prominent values. In doing so, Americans idealize the Dalai Lama and his

religious group, failing to see socio-economic injustices in the region and non-Western interests. Yu's analysis illustrates how popular texts about the given subject area may be collected and examined in terms of their overarching narrative structure, the cultural values which they communicate, the characterization of those plotted, and the interests, values, and voices silenced in narrative production.

Because master narratives are analyzed at a macro-level, their relationship to micro-level interactions may not be teased out in research. However, the relationship between master and personal narratives is an important undercurrent in this research and asserts that master narratives powerfully shape personal narratives. Master narratives are distinguished from personal narratives in that they are "collective stories that govern the existence of a collective subject, or group, in such a way that they shape the 'personal' identities and narratives" (Esteban-Guitart, 2012, pp. 175-176). Such a view highlights the power of master narratives over the individual, but a master and personal narratives have a dialogic relationship as master narratives shape personal experiences, behavioral choices, identity, and storytelling and as personal narratives are communicated within groups and shape group storytelling. Scholars express concern over the implications of master narratives for individuals' lives; especially those silenced and marginalized in the master narrative. Such works often draw upon Foucault's (1980, 1995) discussion of disciplinary power arguing the disciplinary power of master narratives for individual's actions, identity construction, and social relationships. Despite the controlling and disciplinary findings related to master and personal narratives, narrative inquiry has also found resistance to these narratives (Bamberg, 2004).

Resisting, even if partially, master narrative meanings, counter narratives challenge the dominant, taken-for-granted meanings. Bochner and Ellis (2006) point out, narrative meanings are imbued with the “canonical stories that circulate in one’s society” whether meanings reproduce, transform, or resist the canonical stories (p. 116). Those narrative meanings that transform or resist the canonical, or master, narratives are termed counter narratives, alternative narratives, and/or resistance narratives within the literature. In terms of health communication, Japp and Japp (2005) demonstrate how master narratives delegitimize alternative narrative constructions of health while counter narratives can generate perceptions of legitimacy. In their analysis of Chronic Fatigue Syndrome (CFS), the counter narrative of pain and suffering is popularized through recounts of Laura Hildenbrand’s life experiences as writer and CFS patient. As this counter narrative of CFS is dispersed through the media, it constructs legitimacy for the disease and experiences of those living with it. The personal became public and contributed to dialogue about the legitimacy of biomedically invisible diseases like CFS.

Exemplar Master Narrative Research

Exemplar master narrative research has examined master narratives of obesity (Shugart, 2011), decline and entrepreneurialism (Trethewey, 2001), maternity and ideal entrepreneurial workers (Buzzanell & Ellingson, 2005), reengineering and the disposable worker (Boje, Rosile, Dennehy, & Summers, 1997), marriage (Bergen, 2010), domesticity and the ideal worker (Williams, 2001), and biomedicine (Japp & Japp, 2005). The majority of these studies note cultural shifts and discourses documented in popular culture and/or the academy to construct a master narrative. Next, the researchers

critically examine the power implications of the master narrative to determine which meanings and people are privileged and marginalized through storytelling. Finally, the researchers recommend or present resistance/alternative narratives and/or changes that would alter the social structures that (re)produce the master narrative.

To illustrate this analytic process, consider Buzzanell and Ellingson's study of the ideal entrepreneurial worker and maternity. As Buzzanell and Ellingson (2005) find with Tara, a photo technician, and her maternity story, the larger social discourse of what constitutes an ideal worker (canonical story or master narrative) shapes how Tara and her employers interpret her pregnancy and organizational role. While this social context is often a taken-for-granted natural order, narrative inquiry seeks to illuminate this social context and its effect on narrative meanings (Mumby, 1987). By Tara voicing resistance to social constructions of the ideal worker, Tara generated alternative meaning for what constitutes an ideal worker (Buzzanell & Ellingson, 2005). Her resistance storytelling illustrates how narrative is used in *struggles over meaning* to generate additional layers to the social context (Mumby, 1993, p. 5). Furthermore, her resistance storytelling reinforces proposed feminist agendas related to maternity leave and organizational policies.

In a closely aligned vein of research to the scope and aims of this study, Shugart (2011) uses master narrative methods to examine the contemporary narrative of obesity in three popular culture texts (*The Biggest Loser*, *Oprah*, and *Big Medicine*). Her critical rhetorical approach "loosely combine[s] ideological and thematic analytical techniques" (p. 39). Shugart simultaneously explores common symbols (verbal, visual,

and contextual) that cohere into the structure of a narrative (thematic analysis) and critiques how the emergent narrative attributes responsibility and functions with regard to power struggles (critical rhetorical or ideological analysis).

Applying Master Narrative Analysis within this Study

Patterning my methodological approach to studying master narrative after Shugart's, I examine common symbolic characterizations of pediatric nutrition in birth through one year to construct a coherent narrative of nutrition. First, I read through the *Parenting* articles, books, booklets, brochures, resource websites, and blogs to: get a general understanding as to the language used to talk about pediatric nutrition, to identify preferred feeding practices and the target audiences of these instructions, and build preliminary categories for open coding. The basic narrative components of plot, character, scene, chronology, and context were central in open coding. My notes identified three significant temporal periods, in which parents were targeted with nutrition instruction – pregnancy, birth through 4-6 months, and 4-6 months through 12 months. By noting temporality, I began to see how plot, characterization, action, motive, values, sequencing, and moral clustered based on time. During this process, I noted that several different narratives emerged based on their motivations to achieve natural feeding. While the labels for these narratives remained tentative, I noted four narratives: strict naturalism, moderate naturalism, limited naturalism, and synthetic acceptance.

Second, I began to systematically record quotes from data that cohered around these different narratives of pediatric nutrition. To assist with this process, I outlined and charted out the plot development of each and went back to the data to document

representative quotes of the plot developments. By far, this was the most time-intensive process. For each narrative, I began documenting *Parenting* and parenting.com articles, blogs, and other instructional messages (primary textual materials) that related to the narrative development. For the master narrative, moderate naturalism, discussed in Chapter III, the primary texts contained ample representative quotes, but I also used secondary texts to add layers of description to narrative components and demonstrate the consistency of the master narrative across texts. For the counter narratives discussed in Chapter IV, *Parenting* and parenting.com were more and less helpful in narrative construction, which led me to secondary texts. For example, *Parenting* contained few articles during the 16-year time span that discussed the plot of strict naturalism. However, parenting.com has web-based articles and blogs stamped “100% Grade A Natural Parenting,” and secondary texts such as the Organic Resource Center website and Knight and Ruggiero’s (2010) book *The Best Homemade Baby Food on the Planet* provide detailed instruction on the feeding practices and products associated with strict naturalism.

Third, I began noting implications of the plots in terms of authority, responsibility, accounting of context, and delegitimizing alternative narrative constructions. In other words, I began to engage in critical rhetorical analysis to show how the master narrative, and even the alternative narratives, privilege certain meanings, power relations, and family structures over others. The results of this form of analysis are reported in Chapter V. Fourth, I integrated master and alternative narratives and formulated recommendations to a voice of authority within pediatric nutrition -

pediatricians. Master narrative approaches assume a dialectical relationship between the master and counter narratives and seek to tease out this relationship by examining how dominant meanings are being contested and deconstructed through subversive storytelling (Buzzanell & Ellingson, 2005; Martin, 1990, 1992). A postmodern approach to master narrative analysis “defends living and social bodies against the grand narrative,” (Boje, 1995, p. 1004) which “lead[s] to discursive closure in the sense of restricting the interpretations and meanings that can be attached to” the subject of study (Mumby, 1987, p. 113). By re-storying narrative discourse in a way that legitimates and normalizes subversive storytelling, a plurality of narratives become legitimized, and discursive closure makes way for discursive possibilities. If the ultimate aim of this study is to transform pediatric nutrition instructional messages, then the message must be circulated beyond the scope of communication scholars. Or, put another way, re-storying pediatric nutritional narratives must build community with those for which it can make a difference (Sharf & Vanderford, 2003; Sharf et al., 2011). The process of building community is modeled in Chapter VI.

Conclusion

In sum, this chapter has laid the theoretical foundation for studying health communication and narrative by reviewing narrative health communication research, the narrative paradigm and narrative rationality, narrative components, the textual materials to be analyzed, and the methods for analyzing those texts. More specifically, Chapter II has outlined the process modeled by master narrative studies and how the process was applied to the pediatric nutrition instructional texts included in the primary and

secondary sets of texts. At this point, this study progresses to the data analysis chapters to answer the two of the three guiding research questions identified at the outset of

Chapter I:

RQ1: How do pediatric instructional messages from birth through one year construct a master narrative of nutrition and plot of parenting?

RQ2: In what ways are the master narrative and its plot of parenting contested and transformed in pediatric instructional messages?

Chapter III will focus on answering RQ 1 by using *Parenting* and parenting.com articles and other secondary textual sources to understand the plot structure and other narrative features of the master narrative. Then, Chapter IV will address RQ 2 by teasing out alternative narrative plot structures and features demonstrating how they diverge and converge with the master narrative. Transitioning into Chapters III and VI, this study is taking seriously the social construction of reality for parents, in regard to how they should and should not feed their children, by identifying the ways this reality becomes *fixed* in pediatric nutrition texts (Mumby, 1993, p. 7).

CHAPTER III

MASTER NARRATIVE OF MODERATE NATURALISM

Daniel, my youngest of three sons, was about 11 months old when my husband and I invited our friends, whose son was 14 months old, over for dinner. We all sat down to eat our spaghetti, broccoli, salad, and bread. The subject of discussion at the dinner table quickly migrated to our children's eating habits as our guests interacted with our three boys during mealtime. Our friends marveled at how Daniel ate spaghetti, sauce and all, that I had blended in a food chopper and added water, while their son munched on toddler ravioli. Questions quickly arose like, "Are you concerned about seasoning?" "Is it okay to give him wheat products prior to 12 months old?" "Do you worry about choking?" "Do you let him snack or only eat solids at meal times?" "Have you already introduced all of the ingredients one by one to make sure he doesn't have a food allergy?"

I smiled and answered each question in stride, understanding that they were concerned about adherence to the baby feeding instruction that they read in books, articles, and online. Certainly their concerns were valid and representative of the concerns I had read about in my own research on pediatric nutrition and baby feeding practices. What was difficult for me to shake was the mix of fear and awe expressed toward my family's eating habits. Why was this couple so fascinated by the Spradley family mealtime and, specifically, Daniel's eating patterns? I conjecture that we broke the mold for our guests by challenging the advice that they had internalized and practiced in their own family. The feeding instruction that they believed hook, line, and

sinker is the subject matter of Chapter III and comprises the powerful master narrative of pediatric nutrition birth through 12 months.

Chapter III is positioned to answer the first research question posed in Chapter I.

RQ1: How do pediatric instructional messages from birth through one year construct a master narrative of nutrition and plot of parenting?

Piecing together the master narrative of pediatric nutrition and parenthood in the first year of a child's life, the texts reveal three primary chronological periods, in which parents are responsible for making nutritional choices on behalf of their infants: pre-birth nutritional preparation, birth-six months milk diet, and six through 12 months introduction of non-milk liquids and solid foods. In each of these periods, parenting is conflated with mothering. The maternal role takes center stage, casting mom as nutritional decision maker, problem solver, and risk reducer. The following sections utilize quotations from *Parenting* magazine and its website along with secondary texts to demonstrate how parenting, or mothering, expectations are socially constructed in relation to nutrition in the master narrative of moderate naturalism.

Overview of Moderate Naturalism

Moderate naturalism is the master narrative of pediatric nutrition that flows out of prescriptive messages to parents. The emphasis pediatric nutrition instructional texts place upon natural feeding products and methods (e.g. breastfeeding, breast milk, 100% natural juices) constructs a master narrative and alternative narratives that center on the degree to which feeding integrates naturalistic practices and nutrition. Moderate naturalism is the label I use to describe the master narrative of pediatric nutrition

instruction because natural products and methods are preferred and implemented in feeding but supplemented with products and methods that are considered to be synthetic/artificial, processed, and/or containing additives. See Appendix B “Master Narrative of Pediatric Nutrition Birth through 12 Months” for a snapshot of the progression of moderate naturalism and maternal role there within. This timeline in Appendix B functions to assist in understanding the chronological sequence of prescribed feeding actions expected within moderate naturalism and the primary maternal role featured in each of these periods. These actions are reflective of motivations to avoid health risks and optimize maternal and child health by meticulously adhering to expert advice presented in parenting texts.

During pregnancy, parents are instructed to prepare for child feeding, become educated about breastfeeding, and purchase products to ready themselves to feed their children. Upon the child’s birth, she is to be breastfed exclusively until a time period negotiated by parents and pediatricians between the four and six month developmental marker and, at this time, introduce solid foods while continuing to breastfeed through 12 months. While exclusive breastfeeding is the child feeding method and human milk is the nutritional product of choice in moderate naturalism, instructional advice permits limited formula supplementation per medical professionals’ recommendations and informed parental judgment. At 4-6 months the introduction of solid foods begins. Starting with rice cereal and proceeding with pureed/smashed produce and 100% natural juice, parents are to introduce one food at a time to their children building up to three meals and two snacks per day by the one year developmental marker. Overall, parents

are to be highly educated about the nutritional value of foods and liquids for physical development, the methods to overcome feeding challenges, the safety risks of specified foods and feeding practices, the signs of food allergies, and the ways to cultivate a healthy eater. The following three sections provide a detailed description of nutritional directives targeted to parents in three different chronological periods: 1) pregnancy, 2) birth through 4-6 months, and 3) 4-6 months through 12 months.

Pregnancy: Nutritional Preparation

Pregnancy is a time-period in the parenthood plot that represents preparation. During this time period expectant parents are introduced to a variety of breastfeeding messages ranging from serious to romantic to humorous. *Parenting* magazine casts this act in the parenting plot as both a 1) *biological preparation* for the maternal body and fetus and 2) an *educational preparation* for the parental unit to nourish their newborn.

Biological Preparation

In nutrition instruction texts, pregnancy is represented as preparing the maternal body to produce milk and the fetus to nurse. First, pregnancy marks a time of rapid change in the maternal body. By emphasizing the maternal body from the outset, instructional texts construct parenthood and its related infant feeding responsibilities with the mother. Her body is storing calcium for breastfeeding (Curtis & Schuler, 2004), and one of the first visible changes is to the breasts. Describing these changes, Hayman (2002) tells expectant mothers that: their veins will increase in size, their breasts will increase in size and tenderness, their areola will darken and develop small bumps (glands), and their nipples will likely leak during the last trimester. What's more, the

language evoked in these instructional texts cast the breasts in a prominent role during pregnancy. To illustrate, Reek's (1998) article personifies the breasts as on a mission from conception to weaning.

For a woman's breast, pregnancy marks the role of a lifetime. As soon as they get the hormonal signal that this month's egg has been fertilized and implanted in the uterus, those amazing mammary glands start cooking. Almost before you know it, they grow by leaps, bounds and cup sizes on the outside, while furiously developing a milk production network on the inside. After all, pregnancy – or its culmination, a tiny mouth to feed – is what women's breasts have been waiting for since puberty. Here's an insider's guide to what's happening and what you can do about the aches, pains, drips, and droops that can affect pregnant breasts from conception to mission accomplished.

The breasts are endowed with agency and become characters in the narrative both distinctive from and interdependently linked to the mother. Such characterization may alienate mothers from their breasts when they do not fulfill their biological mission and, subsequently, inhibit mothers from fulfilling social expectations of good mothering – breastfeeding. Failure of the maternal body will be discussed at greater length in Chapter IV.

As characters in moderate naturalism, the breasts are in proper working order when they prepare for lactation. With that understanding, mothers are charged with the responsibility to facilitate the breasts' lactation by taking care of their bodies in pregnancy with low impact exercise and a nutritious diet to enhance the breast comfort

and ability as they fulfill their mission. A number of products are recommended to mothers to facilitate lactation and breastfeeding. In their “role of a lifetime,” women conform to the part, even the wardrobe. Expecting mothers purchase bra extenders, larger bras, breastfeeding pads, and nursing bras in anticipation for the mission.

Time for a super-strength bra. Each breast grows an average of two pounds during pregnancy. “You need to continue to get well-fitted bras as you grow,” says Chris Auer, a certified lactation consultant at the University of Cincinnati (Reeks, 1998).

The biological and consumptive preparation for breastfeeding features mothers and their bodies. However, breasts that do not biologically develop the means to lactate postpartum are silenced in moderate naturalism. As unacknowledged characters in moderate naturalism, the prevailing message denies their existence, or that they exist so infrequently that they do not need acknowledgement. Characterizing the maternal body, instructional texts demonstrate the performative nature of the mother’s body in her identity and conformity to good mothering. These texts intertwine maternity with lactation during the prenatal period and foreshadow which “bodies matter” (Butler, 1993; Shugart, 2010) postpartum –breastfeeding bodies. Pregnancy is framed in terms of its value for preparing the mother for her *role of a lifetime* to breastfeed her newborn and in terms of the breasts’ biological determination to breastfeed. Clearly, instructional texts cast mothers in the lead parental role while other supporting characters receive little attention within the texts.

Anticipating and transitioning to take their parts, for many women motherhood is a turning point in their lives as they learn to construct, negotiate, and enact their role as mother (Miller, 2005; Stamp, 1994). Nevertheless, worry, confusion, uncertainty, and other possible negative emotions are depicted as adversarial to the biological mission of breastfeeding, and knowledge is depicted as the sword with which to defeat them. One *Parenting* article phrases it this way, “But knowledge is power; if you learn all you can about breastfeeding, you’ll be better able to keep yourself—and your baby—on track” (Neifert, 2002). *Parenting* articles highlight a mother’s preparation for infant feeding as the fetus develops in her womb, but the publication equally highlights how the fetus’ body is developing in preparation for breastfeeding.

Second, the fetus is described as biologically determined to breastfeed. *Parenting* (1999) magazine features articles like “The Nursing Instinct” that emphasize role preparation in fetus development.

You aren’t the only one preparing for breastfeeding. Starting in the first trimester, your baby-to-be is developing the three reflexes he’ll need to be able to eat. By 11 weeks, a fetus can swallow. By 24 weeks, he can suck. By 32 weeks, he has developed the rooting instinct (which means he’ll turn his head in search of food when his cheek is stroked).

The fetus’ breastfeeding development coincides with the maternal body. In the case of the mother, instructional advice paints a picture of a natural trajectory to which her experiences and choices will be subordinated. In the case of the child, instructional advice also paints a picture of fulfillment toward this trajectory or plot sequencing.

Loschert (2008) describes this natural trajectory in simple terms: “Babies are programmed to nurse until after they turn 1.” At this point, a question arises: If maternal bodies and babies are biologically determined to breastfeed, then what, if anything, should a parent do to prepare for child feeding?

Educational Preparation

Throughout each of the three trimesters leading up to the birth of the child, parents are targeted with messages that instruct them to choose the best feeding method for them and their child and to become educated about feeding in order to make the healthiest choice. Educational messages recommending breastfeeding assume that characters – parents and, more specifically, mothers as lead characters – have the agency to direct narrative action, control the scene, and determine plot. These messages reveal four themes within educational preparation: 1) parents have choice; 2) parents should become educated, specifically about breastfeeding, to make the best choice and only acceptable choice; 3) parents should select breastfeeding because it is the most mutually beneficial choice for parents and their child; and 4) parents should consider the consequences of their choices in determining the plot and sequencing of pediatric nutrition.

Parents Have Choice. First, education preparation is described in terms of seeking out information through texts and relationships that will facilitate effective nutrition decision-making. Instructional texts assume that parents may choose from multiple feeding methods. Consider the words “plan,” “choice,” and “decision” found in the following texts focused on educating parents about breastfeeding.

If you plan to breastfeed... (Reeks, 1998)

How has such a personal choice [breastfeeding] become such a public issue ?

(Crane, Heyworth, & Clower, 2012, p. 73)

Your decision about breastfeeding is a personal one. (Curtis & Schuler, 2004, p. 395)

These exemplary quotes emphasize the personal, yet publically scrutinized, decision making regarding infant feeding. While some limitations to choice are acknowledged (e.g. changing scenes from home to work, contexts of adoption and premature birth, etc...), the overarching message constructed in pediatric nutrition discourse is that parents are able to control feeding choices and, thus, feeding outcomes.

Parents Should Become Educated. Prior to labor and delivery, parents are expected to become educated about the child feeding methods and pediatric nutrition by seeking out information published and customized for them. Self-education, that is education initiated by the parents through reading instructional messages about pediatric nutrition, is described as vital to effective decision-making. As the authors of *What to Expect the First Year* put it, “No matter what’s causing your indecision, or your ambivalence, or your confusion about the right baby-feeding method for you, the best way to bring that fuzzy picture into focus is to explore the facts, as well as your feelings” (Murkoff & Mazel, 2010, p. 5). The Joint Commission’s Speak Up campaign brochure advises parents to become educated and active in regard to 10 action items including, “Learn about breastfeeding. Go online, read books, take a class and talk with other moms who have reached their breastfeeding goals.” Pediatric nutrition instruction

communicates concern about the lack of education and encourages parents to follow through with information-seeking behavior. Instructional texts appear confident that self-directed education about breastfeeding will guide parents to choose breastfeeding prior to labor and delivery. While some instructional texts like *What to Expect the First Year* (Murkoff & Mazel, 2010) will present information and motivations related to formula feeding (although the quantity of information is greater in relation to breastfeeding), most instructional texts limit parental exposure to positive information and motivations related to formula feeding while emphasizing positive information and motivations related to breastfeeding.

Parents Should Choose Breastfeeding Because It Is Mutually Beneficial.

Instructional texts position themselves, as authorities, to help parents make choices that are mutually beneficial for parents and their child. Awaiting labor and delivery, parents are targeted with arguments to choose breastfeeding over formula feeding due to the advantages it affords both infant and mother. In the Appendix C entitled, “Mutual Benefits of Breastfeeding,” the reoccurring benefits to child and to mother are listed with exemplary quotations for each. The benefits to child include: obesity prevention; protection against environmental pollutants, ear infections, respiratory infections, common cold, flu, and asthma; risk reduction for Sudden Infant Death Syndrome; neurodevelopment enhancement; and development of healthy eating patterns. The benefits to the mother include: release of hormones oxytocin and prolactin; breast cancer risk reduction; versatility of breast milk as a natural antibiotic; improved body shape/figure; decreased financial burden; and intangible reward associated with

motherhood. Breastfeeding is socially constructed as a win/win choice for mothers and their children, but little to nothing is said as to how it is beneficial to other characters, such as fathers, in the pediatric nutrition narrative or how it may have substantive drawbacks to children and their families. Furthermore, mothers, to whom are attributed the primary responsibility for decision making, are expected to choose breastfeeding, which begs the question as to how much choice they are given.

Parents Should Consider the Consequences of Their Choices. Inevitably, pediatric nutrition instruction stresses the consequentiality of parental choices for them, their children, and their future decision-making. The discourse draws attention to the relationship between breastfeeding and formula feeding choices, and how these choices either limit or enable future feeding choices. In other words, parental choices about child feeding can cause irreversible changes in the feeding options available for parents to select from. Lactation is dependent on stimulation, therefore, making it difficult to impossible to resume breastfeeding if it was not initiated and continued consistently. This is crystalized in discussions surrounding the choice to breastfeed or formula feed. In the AAP's handbook on baby care during the first year, the consequentiality of feeding decisions are worded as such:

But you should thoughtfully weigh the many benefits of breastfeeding for yourself and your baby before making the choice to formula feed. It's important that you give it serious consideration before your baby arrives, because starting with formula and then switching to breast milk can be difficult or even impossible if you wait too long. The production of milk by the breast (the process

called lactation) is most successful if breastfeeding begins immediately after delivery. If you begin breastfeeding and then, for any reason, decide that it's not right for you, you can always switch to formula (Shelov, 2010, pp. 95-96).

Sears et al. (2013) reinforce this same message of breastfeeding for a trial period, "If you are still undecided by birth time, give breastfeeding a thirty-day trial, using all the right-start tips on page 137. It is easy to go from breast to bottle, but the reverse is very difficult" (p. 31). The "Try it; you might like it" method of convincing children to eat their vegetables and try new foods seems to be a similar strategy employed in instructional texts regarding breastfeeding. Whereas a child may have many more opportunities to try a food, mothers have only a limited opportunity to begin lactation and build a milk supply necessary for breastfeeding.

Instructional messages direct mothers to put baby to breast as soon as possible postpartum in the hospital to initiate breastfeeding practices. "Research shows that when you don't start breastfeeding in the hospital, you aren't likely to start later" (Crane, Heyworth, & Clower, 2012, p. 74). Therefore, parents are encouraged to inform the hospital labor and delivery, nursery, and postpartum nurses about their choice to breastfeed and to follow through with this choice in the hospital. Parents are to be educated, plan to breastfeed, and take proactive measures to ensure that breastfeeding occurs quickly following delivery.

The emphasis on baby feeding decision-making prior to labor and delivery stresses the value of parental education about the short-term and long-term consequences of their pediatric nutrition choices. Expectant parents may chuckle at articles like

Balmain's (2012), "Suck it! The Real Way to Prep for Breastfeeding," which uses humor to parody the postpartum breastfeeding role. Balmain coaches pregnant women with directives like, "At bedtime set your alarm clock to go off every two hours. Each time it rings, spend 20 minutes sitting in a rocking chair with your nipples clamped by a pair of chip clips." While producing a good laugh, Balmain's article is a drop in the bucket of breastfeeding preparatory messages. Once more, such advice draws attention to the lead character and decision maker for child feeding – the mother, who will be getting up to breastfeed baby.

By Parenting, Texts Really Mean Mothering. When instructional texts discuss parental decision-making and its consequentiality, what they really mean to say is mothering. First, pediatric nutrition instructional texts conflate parenting with mothering by either directly or indirectly targeting mothers with education. This section explains how this characterization process is accomplished, the ways in which the character conflation is resisted, and the implications. Mothers are the primary target audience for pediatric instructional messages. *Parenting* (2003, 2006, 2007, 2008) features "mom answers," "mom debates," and "mom polls" in the magazine with no counterpart for other caretakers. The pregnant maternal body is a mainstay and highlighted in articles like "A New View of the Womb," which reminds mothers that the consequences of their nutritional choices begin in pregnancy (Barnett, 2002a). The exception is the specialized "dad" section on the magazine's website, which does not contain educational articles about pediatric nutrition birth through 12 months in favor of content about celebrity dads, dad-child relationship development, sex and marriage, and modern dad issues like

being a stay-at-home dad. Consequentially, the maternal identity becomes synonymous with the duties to which it is prescribed, feeding. To further illustrate, consider the AAP's infant care manual (Shelov, 2010). The text begins with a chapter entitled, "Introduction: The Gifts of Parenthood." In this chapter, the gifts received by parents are described as unqualified love, absolute trust, thrill of discovery, and heights of emotions experienced. The chapter also describes gifts parents provide for their children as unconditional love, self-esteem, values and traditions, joys in life, good health, secure surroundings, and skills and abilities. From the outset the text refers to the readers with the pronoun *you*. While the term *parents* and the pronoun *you* are used throughout the chapter, the writers often mean *mother*.

Case in point, when discussing the gift of good health, the text states, "Your child's health depends significantly on the care and guidance you offer her during these early years. You begin during pregnancy by taking good care of your self and by arranging for obstetric and pediatric care" (Shelov, 2010, p. xxvi). Part 1, chapter 1 is focused on parental preparation; yet, the focus of the chapter is on the mother's health as it relates to the fetus' development and establishing health care relationships and health conscious practices within the home. At one point in the chapter, there is a two-paragraph section singled out in a text box labeled, "Preparing Dad for Delivery." While reading, I wonder why a book written to parents needs to label the section for the dad. Once more, to clarify that this is the section for fathers to read, the first line of the section reads, "If you're the father-to-be, remember that having a baby is a family event"

(p. 42). When *you* is used throughout the chapter, it seems to connote *mother* unless labeled otherwise. The understood *you* is understood as *mother*.

By addressing mothers as the audience of parental advice, *Parenting* and other instructional texts are reproducing gender roles that socially construct inequities within the division of household labor. The mother is empowered, in a limited sense, to make nutritional decisions and increase her nutritional knowledge. She has within her grasp the ability to direct the nutritional path for her household beginning with breastfeeding. This neoliberal construction of empowerment (Dubriwny, 2013; Shugart, 2010) is limited in two ways. First, as indicated earlier, breastfeeding discourse warns mothers about the health risks associated with formula feeding. Therefore, to be perceived as a good mother, she realizes that she must choose breastfeeding. In other words, child health outcomes are not biologically determined, but instead, conceived of in terms of an amalgamation of decision-making – in this case maternal decision-making to breastfeed. She defers to the scientific evidence presented to her by instructional texts, which resound with airs of objectivity in their pursuit to help mothers care for their children. Secondly, empowerment succumbs to responsibility. Yes, maternal decision-making situates mothers in the metaphorical driver's seat, but with that seat comes the full weight of responsibility for her choices and implementing these choices. While numerous concerns surround responsibility, an important yet unaddressed concern is context. Decontextualized instruction fails to account for such issues as single-parent households, education level, extended family caregiving, dual income earning households, ethnic and cultural differences, socio-economic status (SES) differences,

and the list goes on. These contextual issues may enable and/or constrain the maternal ability to implement breastfeeding decisions. It is decontextualized instruction that further draws attention to whom instructional texts are speaking – women who have access to support from medical practitioners and instructional texts, have the health literacy to read and understand a wide array of instructional resources, and have the time to dedicate to breastfeeding.

Next, instructional messages gloss over potential conflicts mothers may have with other characters in terms of their nutrition narrative preferences. If parental practices are a result of negotiated social expectations, then pediatric nutrition instruction does a poor job in discussing ways in which parents can negotiate nutrition narratives between one another and with other caretakers. In a blog post about conflicts over natural parenting choices, Taylor Newman (29 February 2012) writes,

Of course conflicts over parenting choices are *guaranteed* to come up, no matter how closely aligned each parent's attitudes; hopefully we all go into this family thing prepared for compromise. But when feelings are strong, and stakes are high (these conversations all essentially boil down to kids' health and happiness, no?), coming to mutually agreed upon conclusions can be easier said than done (para. 2).

This rare reference to multiple caretakers aptly points out their inevitable competing interests. Instructional texts assume that fathers and other caretakers will simply support maternal decision-making and, at the very most, influence mothers to make the right decision, which is to breastfeed. While little is said directly to these [peripheral]

characters within the instructional texts, it is clear that their role is to enable women to breastfeed. By labor and delivery, these decisions must be finalized because mothers have a limited window of time to initiate and establish breastfeeding.

Birth through Four-Six Months: Milk Diet

The preferred child feeding practice from birth through 4-6 months is exclusive breastfeeding or bottle-feeding of expressed breast milk with low levels of formula supplementation as agreed upon between parents and their pediatricians. Parents have been inundated with messages that promote exclusive breastfeeding during pregnancy, and now, these messages cohere as their child emerges from the womb to be placed at the breast for the first time. The alert newborn is to be placed at the breast “the first hour or so after birth” to begin breastfeeding in order to promote the production of colostrum – a sticky, yellow pre-milk substance that fits the baby’s needs in the first few days of life before the mother’s milk comes in (Shelov, 2010, p. 50).

Every 1.5 to 2.5 hours, the newborn is to be placed at the breasts to nurse for 8-10 minutes per breast resulting in 8-12 feedings per day in the first month of his life. After this pattern of nutrition is established, the baby will consume a greater amount of breast milk at each feeding, subsequently, needing to nurse less often as dependent on the baby’s weight gain, stomach size, and eating patterns. The plot is complicated by the challenges that threaten breastfeeding exclusivity and continuance. *Parenting* describes the perception of natural and easy versus the reality of difficult and challenging. “Breastfeeding sounds simple enough: boob + baby = done. The reality, however, can be a bit more complicated” (Anastasia, 2012). Engorged breasts, cracked nipples,

bleeding nipples, uncertainty about milk quantity, waning milk production, clogged milk ducts, mastitis, fatigue, frequency of feedings, feeding in public, lack of social support, and return to work are the most frequently noted difficulties that may steer a mother off course from her *role of a lifetime* as breastfeeding mother. Therefore, instructional texts continue to argue the merits of breastfeeding citing experts and offer up solutions to common breastfeeding problems to ensure that mothers do not veer off track.

Breastfeeding

Breastfeeding is natural, in the sense that human lactation is a physiological process of milk production and nursing is the means by which the human milk is transmitted to a child. Nevertheless, breastfeeding correctly does not necessarily come naturally to mothers and their children. An article on the BabyCenter resource website puts it this way, “Breastfeeding is like a hike through the woods: Natural, but not always simple” (Babycenter.com, 2011a). Pediatric nutrition discourse acknowledges that breastfeeding may seem “completely foreign” and unnatural to mothers who grew up during a time period in which formula feeding was the norm (Crane, 2012). To increase levels of comfort with breastfeeding, instructional messages use two stylistic language devices: breast humor to normalize breastfeeding and technical language to increase breastfeeding efficacy.

First, breast humor is commonplace in pediatric nutritional discourse. Breast humor is a term that I use to describe the forms of humor used in instructional texts such as puns, satire, situational humor, and irony. Breastfeeding obstacles are referred to as “booby traps” (Meitner, 2012, para. 1), and supporters are referred to as “breast friends”

(Crane, 2012). The breasts themselves can be called “dairy faucets” (Babycenter.com, 2011a, para. 13) while moms sometimes call themselves “dairy cows.” Despite the vast majority of breastfeeding instruction stressing the magnitude of breastfeeding decision-making and the health consequences associated with breast versus formula feeding, humor is a stylistic device that takes the edge off, lightening the mood. Simultaneously, humor further normalizes lactation, breastfeeding, and pumping by taking a topic previously considered private and taboo and making it public and lighthearted. Whereas breastfeeding humor increases comfort with the breasts’ function in moderate naturalism, breastfeeding technical advice promotes maternal self-efficacy – the belief that the mother can fulfill the breastfeeding role by applying tips and strategies to nurse her baby. Sears and Sears (2000) explain the correct breastfeeding strategies: “Make sure your baby’s mouth is open as wide as possible. Express a drop or two of milk onto your nipple, then use the nipple to tickle her lower lip. If that doesn’t encourage her to open her mouth, use your index finger to press down on her chin as you pull her onto the areola” (p. 124). Breastfeeding is described as a technical process requiring specialized knowledge, experience, expert assistance, and strategy. This is in stark comparison to idealized descriptions of breastfeeding that construct images of happy, cooing babies easily latching on to their mothers as their mothers gaze back at them in delight. Murkoff and Mazel (2010) describe breastfeeding as both potentially “blissful” and quite probably frustrating (p. 66). Because of the varied experiences of breastfeeding mothers, instructional texts allocate column space, webpages, and book pages to address breastfeeding motivations and “how to’s.” In order to reinforce the decision to

breastfeed and motivate mothers to overcome breastfeeding challenges, the superiority of breastfeeding as a process and breast milk as a product become reoccurring themes in nutrition instruction.

Superiority of Breastfeeding as a Process. Breastfeeding is a process, in which mothers must acquire experiential knowledge of practices including holds (e.g. football and cradle) and latch to ensure that their children are adequately feeding. The challenges to breastfeeding, like bleeding nipples and returning to work, threaten the social construction of breastfeeding as natural because of the labor and knowledge required to overcome such challenges. Consider the following introduction to an article on nursing advice:

Breastfeeding may be rewarding, convenient, and cost-efficient, but it can also be difficult, exhausting, and sometimes painful – especially during the first few days. Here are some ways to get over the hump (Lanigan, 2000, p. 1999).

Breastfeeding difficulties complicate the parenting plot associated with the master narrative of moderate naturalism. However, instructional texts emphasize the superiority of breastfeeding as a process and advocate that mothers continue to breastfeed despite challenges. Messages that focus on the benefits of breastfeeding as a process tend to emphasize the physiological and psychological outcomes. There are two primary arguments used in instructional texts to assert the superiority of breastfeeding as a process and, thus, promote continued breastfeeding: 1) breastfeeding facilitates mother-child bonding and 2) breastfeeding produces hormones to increase mothers' pleasure.

First, to ensure that breastfeeding moms continue to implement breastfeeding during the first year, pediatric nutrition instruction argues that breastfeeding facilitates mother-child bonding. Soler (2012) features mom stories in her article on breastfeeding. One of these mothers claims, “It’s [breastfeeding] an amazing feeling; it feels good, and the bonding is like none other.” Breastfeeding is framed as a way to accomplish one of the most sought after experiences of parenthood – bonding between parent and child. Dr. Sears (2001) recommends, “If you can, nurse as often as possible. Holding your baby close while you give her nourishment can create an intimate connection that few other activities match” (p. 99). The process of breastfeeding becomes synonymous with terms such as relating, bonding, and connecting. In other words, to bond with your child is to breastfeed your child.

Second, breastfeeding produces a physiological release of hormones that increase mothers’ pleasure. Dr. Anne Montgomery, professor of family medicine at the University of Washington, is consulted by *Parenting* in regard to a reader question about breastfeeding and arousal. The doctor explains that oxytocin and prolactin are two hormones that are released during breastfeeding, usually between the third and sixth months. “‘Breastfeeding is supposed to be pleasurable,’ explains Dr. Montgomery. ‘That’s how nature makes sure babies will get fed’” (Nursing’s feel-good effects, 2004, p. 68). A number of baby care manuals including Sears et al. (2013) and Murkoff and Mazel (2010) suggest that the release of oxytocin and prolactin may reduce the risk of postpartum depression. The physiological response of the body to milk “let down” and

lactation cannot be simulated through formula feeding and, thus, generates an argument for the superiority of breastfeeding to formula feeding in the literature.

In both cases, the process of breastfeeding is described in terms of what mothers stand to gain from nursing their babies. In this characterization of mothers, good mothering evokes self-gain rather than pure selflessness, a slight departure from feminist critiques of totalizing motherhood reviewed in Chapter I. With that said, self-gain is a noted postfeminist theme. Gill (2007) writes, “Notions of choice, of ‘being oneself’ and ‘pleasing oneself’, are central to the postfeminist sensibility” that pervades Western culture (p. 153). The autonomous postfeminist mother is represented as freely selecting the most advantageous feeding method for herself, but a critique of postfemininity reminds us that the gain-frame message aimed at mothers reifies 1) traditional gender roles, 2) risk management, and 3) self-discipline. To clarify, within persuasion literature and, more specifically, within health communication campaign literature, gain-frames are persuasive appeals that highlight the positive outcome of complying with a health behavior, and conversely, loss-framed messages highlight the negative outcome of noncompliance to the health behavior or inaction (O’Keefe & Jensen, 2007; O’Keefe & Nan, 2012; Tversky & Kahneman, 1981)⁵. First, enhanced maternal-child bonding is a breastfeeding gain-frame that reinforces images of mothers as nurturing, caretakers

⁵ Gain and loss-frame appeals are widely studied as message strategies for health communication campaign design. Despite the overarching opinion that gain-framed messages generate greater audience behavior changes, including intention to change behavior, recent studies have pointed out that a variety of moderating variables, such as perceived difficulty of health behavior (O’Keefe & Nan, 2012), and the type of health behavior (e.g. dental hygiene versus diet and nutritional behaviors as in O’Keefe & Jensen, 2007) impact the outcome of these message strategies. My particular interest in gain and loss-framed appeals is not their outcome measured in women’s intention to breastfeed, but instead, interest resides in their implications for the characterization of mothers and how this either reproduces or resists postfeminism.

within the home. The maternal body rewards itself for the enactment of breastfeeding by releasing a euphoric stimulant, oxytocin, into the body, which is claimed to reduce, not prevent, the maternal risk for developing baby blues and post-partum depression (Murkoff & Mazel, 2010; Sears et al., 2013). Biomedical discourse is co-opted to support constructions of women as uniquely designed to fulfill caretaking activities and receive self-gratification in the process.

Second, both gain-frames are explicitly stated, but their persuasiveness is undergirded by the implied opposites. That is, while a mother stands to gain in the aforementioned ways, she will lose the opportunities to gain if she forgoes breastfeeding. The gain-frames suggest their counterpart loss-frames that formula feeding will not produce the equal bonding or oxytocin for happiness and postpartum depression risk reduction (Murkoff & Mazel, 2010; Sears et al., 2013). Why would the maternal body risk effective bonding with her child? Why would the maternal body risk baby blues or postpartum depression by robbing oneself of oxytocin? Third, these gain-framed appeals to breastfeed function as latent motivators to self-monitor and self-discipline. In other words, gain-framed messages may not be especially important to mothers as they read about them, but as mothers experience challenges to breastfeeding, gain-framed appeals become a means to self-discipline the maternal body through “constant anxious attention, work, and vigilance” to maintain lactation and continue breastfeeding (Gill, 2007, p. 155). Gain frames are not widely noted in feminist critiques of breastfeeding discourse. Attention seems to fall upon loss frames referred to as risks. Nonetheless,

gain frames are situated to bolster appeals as to breastfeeding's superiority and function in a similar self-disciplining manner.

Superiority of Breast Milk as a Product. Not only is breastfeeding as a process described in terms of its superiority but so is the product consumed during breastfeeding – human milk. Breast milk is described as “liquid gold” (Emmons, 2010) and the “perfect food” (Elovson, 2012, para. 1). Driving home the point, one article states, “It’s not false advertising to say that mother’s milk is nature’s perfect food – and it’s no overstatement either” (Whattoexpect.com, 2013a). As a natural source of baby sustenance, pediatric nutrition instructional texts tout its benefits to parents claiming that, “Breast is best at first” (Parenting, 2000, p. 222). From this discourse develops two primary arguments about breast milk’s superiority: 1) breast milk naturally evolves to fulfill baby needs in ways that formula cannot, and 2) breast milk has short-term and long-term health benefits for children that cannot be reproduced in formula. First, breast milk changes during a feeding and over time to meet the developmental needs of the baby. Murkoff and Mazel (2010) describe the changing consistency of milk, “The milk your baby gets is not a uniform fluid in the way that formula is. The composition of your milk changes from feeding to feeding and even within the same nursing session” (p. 70). Breast milk also changes over the course of a baby’s development. Postpartum, pediatric nutrition texts recommend mothers to breastfeed within the first hour of delivery, known as the “power hour,” to provide the newborn with colostrum. Colostrum, termed “magic milk,” is a pre-milk liquid that is yellowish in color and sticky in texture that protects babies against infections, stimulates cell growth, and

purges the baby's body of mucus and meconium (Floyd, 2002; Laura at Parenting, 2013). Two to seven days after delivery, colostrum will dissipate and lactation of transitional milk, a thinner milk higher in lactose and fat, begins (Parenting.com, 2012). Then, approximately 14 days after birth, transitional milk will dissipate and transform into breast milk, which is "even thinner and more watery, but it's still rich in nutrients" (Parenting.com, 2012, para. 8). While formula brands offer different formula for infants and toddlers, formula does not come in colostrum or transitional milk varieties. Plus, formula cannot substitute "when your child (or you) has a minor cut" to act as a natural antibiotic and prevent infections, but all three types of breast milk can (Boone, 2004, p. 56).

Second, breast milk's superiority is explained in terms of short and long-term benefits for children. The underlying claim about breast milk is that, "Breast milk contains the right balance of nutrients for your baby and boosts your baby's immune system" (Mayo Clinic, 2012, p. 58). To view a summation of the benefits of breast milk to baby, see Appendix C entitled, "Mutual Benefits of Breastfeeding." The key short and long-term benefits of breast milk are framed in terms of risk aversion and health enhancement, and representative quotes from texts within moderate naturalism are available in Appendix C. Parents are instructed that they should be motivated to reduce their children's risks related to obesity, environmental pollutants, ear infections, respiratory infections, common cold, flu, childhood asthma, food allergies, and sudden infant death syndrome (SIDS). *Parenting* and other pediatric nutrition texts guide risk averse parents toward breastfeeding as a way to protect their children from negative

and life-threatening outcomes. Often citing experts, *Parenting* articles like Barnett's (2002b) and Hermann's (2002) summarize biomedical research and cite medical practitioners on pediatric nutrition related to breastfeeding's benefits and risks. In moderate naturalism, breastfeeding becomes a risk aversion nutrition project beginning in the first hour after delivery, which is consistent with Wolf's (2007, 2011) findings on breastfeeding research and campaign messages.

Additionally, breastfeeding is a health enhancement nutrition project focused on increasing cognitive ability, facilitating jaw and tooth development, and cultivating a healthy eater. Similarly, health enhancement messages draw upon the credibility of medical research and professionals when advocating breast milk's benefits. For example, *Parenting* argues that research supports claims that breastfeeding will cultivate openness to a variety of foods and flavors. "Need one more reason to consider breastfeeding your baby? Research suggests it's then easier to introduce solids, because infants who nurse are more willing to try new foods" (*Parenting* 1998/1999, p. 284). The research referred to in this article argues that the flavors of the mother's food pass through breast milk to the child, subsequently exposing the child to a greater variety of flavors in the birth to 4-6 month time range resulting in a baby more willing to try different flavored solids in the 4-6 to 12 month time range. According to *Parenting*, cultivating a healthy eater open to experiencing new tastes and textures begins with breastfeeding, which further emphasizes the benefits of breast milk over formula. All in all, the argumentation surrounding the superiority of breastfeeding and breast milk for baby and mother characterizes parents, mothers particularly, as motivated by risk

aversion and health enhancement. Furthermore, this argumentation positions instructional texts and the medical professionals that they cite as the principal supporting cast between birth and 4-6 months. The following section continues to reinforce this characterization as the supporting characters lead mothers to overcome threats to exclusive breastfeeding.

Overcoming the Challenges to Breastfeeding

Challenges to breastfeeding, otherwise known as booby traps (Meitner, 2012), are physiological, psychological, social, and political threats to breastfeeding initiation and continuance. Consider the titles of the following articles on the Baby Zone resource website: “5 Infant Feeding Issues Solved,” “8 Frustrating Breastfeeding Challenges-and Solutions,” and “Breastfeeding Soreness: 5 Ways to Soothe It.” Baby Center’s breastfeeding resources feature 18 articles and 26 Expert Answer posts in a section entitled “Nursing Problems and Solutions” (Babycenter.com, 2013a). Challenges to breastfeeding complicate the plot of moderate naturalism by threatening parents’ ability to fulfill the expectation to breastfeed exclusively for 4-6 months, but each challenge is met with a problem-solution framework. Meitner (2012) writes,

Physical obstacles, such as low milk supply or a bad latch, as well as social ones, like nursing in public, put pressure on well-intentioned moms to toss out their nursing bras and opt for a bottle. “Nursing problems have become an epidemic,” says Diana West, a renowned lactation consultant who co-wrote the latest edition of *The Womanly Art of Breastfeeding*. When breastfeeding doesn’t come easily, “Moms automatically assume they’ve done something wrong,” West says. But

they haven't. They've just faced some obstacles that can seem insurmountable at the time (Meitner, 2012, para. 3).

“Armed with information you need,” mothers are provided with solutions to breastfeeding challenges so that they can enjoy “the precious rewards of motherhood” and remain within the scope of good parenting as defined by moderate naturalism (Neifert, 2002). Appendix D entitled, “Breastfeeding Challenges,” identifies a) the obstacle to breastfeeding, b) whether the obstacle is attributed to child or mom, c) recommendations to overcome the obstacle and continue breastfeeding, and d) supportive quotations from instructional texts.

Breastfeeding obstacles attributed to the child include congestion or stuffy nose, shallow latch, premature birth, multiple births, biting, becoming distracted, nursing strike, and nursing gymnastics. While the baby may be the cause of the breastfeeding challenge, instructional texts clearly attribute to the mother responsibility for resolving this conflict in plot. For example, if the baby is congested, *Parenting* directs mothers to [T]ry holding her in an upright position while you feed her. ‘Your baby may breathe more easily when she’s propped up,’ says Linda Black, M.D., a pediatrician in St. Louis Park, MN. You might also want to nurse her for shorter periods at more frequent intervals to make sure she’s eating enough. If she’s really stuffed up, loosen congestion with a nasal saline solution (Parenting, 2001, p. 33).

The mother must identify the breastfeeding challenge, seek out information about it within instructional texts, and determine how she will continue breastfeeding. While a

stuffy nose is a naturally occurring problem, other problems are described differently. There is a particular type of child-induced obstacle to breastfeeding that casts the baby in an adversarial role. Biting, nursing strikes, and nursing gymnastics are considered deviant child behaviors and place the child in an adversarial relationship to her mother. For biters, McCarthy (2007) recommends one mother's disciplinary advice,

When I've been nipped, I immediately take my child off my breast, sit him up, and say 'No biting!' in a stern voice. I wait a few seconds to put him back on, and if it happens again, I repeat the routine (p. 50).

Biting, which may be due to teething or to stimulate a reaction from mom, is a painful effect of a growing child, not the result of a child plotting against its mother. Yet, this behavior is threatening to moderate naturalism's insistence on exclusive breastfeeding for the first 4-6 months and continued breastfeeding through 12 months. When a challenge to breastfeeding is attributed to the baby, as in the case of biting, the mother is expected to reassert control of the situation by implementing expert advice that allows her to resolve the plot complication and continue to meet the feeding expectations of moderate naturalism. However, the majority of the breastfeeding challenges identified in instructional texts are not causally attributed to child but to the mother.

Breastfeeding obstacles attributed to the mother can be categorized into three overlapping obstacle types: 1) biological/physiological difficulties (e.g. maternal weight management goals, maternal illness, pharmaceutical consumption, fatigue, flat or inverted nipples, sore nipples, clogged milk ducts, mastitis, thrush, milk supply), 2) socio-emotional or perceptual difficulties (e.g. maternal feeding responsibility,

recognizing hunger cues, and generalized emotional reservations), and 3) scene-based difficulties (e.g. return to work and anxieties about feeding in public).

Biological/physiological difficulties range in type, but the general recommendation is to address the obstacle in such a way that nursing may be continued - even in extreme cases in which formula supplementation must be temporarily used and the mother must express the milk with a pump and discard. Common and less threatening biological/physiological difficulties, like sore nipples or clogged milk ducts, can be addressed without having to stop nursing. Mothers with mastitis are told, “Though nursing from the affected breast will be painful, you should not avoid it” (Murkoff & Mazel, 2010, p. 88). Only in the case of specific medicines for which there exists no safe alternative are mothers recommended to pump breast milk, dump the breast milk, and temporarily supplement with formula.

While pediatric nutrition instruction that addresses breastfeeding focuses heavily on biological/physiological difficulties, attention is also given to socio-emotional or perceptual factors that may curb breastfeeding motivation. Socio-emotional or perceptual difficulties include inaccurate perception of hunger cues, generalized reservations about breastfeeding, and concern over the maternal responsibilities associated with breastfeeding. When experiencing these difficulties, instruction encourages mothers to learn more and seek more help from peers, family, and professionals. Addressing the concern that, “It will all be on me,” Meitner (2012, p. 4, para. 4) retorts, “Only if you let it be. Enlist your partner’s help for diaper changes, baths, burping and cuddle time. When she’s about 6 months old, dad can help by

feeding baby her first solids.” In that same article on *Parenting’s* website, Meitner offers this bit of advice to mothers who think breastfeeding is gross or unnatural, “West urges moms to seek out other moms for added support and help overcoming emotional reservations.” Through informational and social support, pediatric nutrition instruction communicates that mothers will be able to change their perceptions and emotions regarding breastfeeding.

The final type of breastfeeding obstacle attributed to mothers is scene-based. The return to work and feeding in public represent two types of scene-based obstacles that threaten breastfeeding based on environment and locale. Much is written to the working mother to help her return to work from maternity leave and continue to breastfeed her baby. The scene of work and the characters within it pose a threat to exclusive breastfeeding. When the scene of work becomes an obstacle to breastfeeding, it is due to the need of a private location to pump, cooperation from the workplace to take pumping breaks, and refrigeration to store expressed milk. While instructional texts assert that these needs are legally protected, it is incumbent upon the mother to request the accommodations, plan accordingly, and follow through with pumping. This is consistent with the postfeminist burden of responsibility falling to the individual mother to take action, control the scene, and perform her competing roles successfully.

To fulfill breastfeeding expectations associated with moderate naturalism, mothers are recommended to purchase or rent a dual, electric pump and begin pumping prior to milk storage needs. Using a breast pump is likened to milking a cow and even vacuuming. Balmain (2012, para. 6) pokes fun at pumping by directing future moms to,

“Fit the hose of a vacuum cleaner over one breast and set on ‘medium pile.’ Turn off vacuum when nipple is three inches long.” Indeed, breast pumping is a new and, sometimes, strange endeavor for mothers but becomes necessary for working mothers who want to breastfeed, for mothers who must cease nursing for a specified time period, and for mothers who want to grant other characters the opportunity to feed the baby. Work is cast in an adversarial relationship to the plot of moderate naturalism. For working mothers, the return to work presents challenges and conflict within the plot. Separation of mother and child threatens milk supply and, thus, threatens good mothering. As Pope (2001) writes, “Juggling breastfeeding and work can be a challenge” (p. 60). This challenge is met with advice on how to successfully manage the role-related expectations of mothering and working. Support from other characters, like coworkers and friends, can be influential and motivational for working mothers to stay the breastfeeding course. Along the way, moms develop tricks of the trade and share them with one another. “I’d leave my car keys inside the bag with my breast milk, then put it in the fridge at work so I’d remember to bring it home,” wrote in Edie Mulligan to *Parenting* (2002, p. 72). One mother uses an electronic schedule to block “20 minutes of pumping time twice a day on my computer’s calendar so that I wouldn’t be double-booked with meetings” (*Parenting*, 2002, p. 72). Being prepared with the right equipment like a pump and “pumping bra,” moms are to take it upon themselves to “ask for special treatment” (Babycenter.com, 2012b, pp. 1-2).

In addition to the work symbolizing a threat to lactation, bottles symbolize threats to successful breastfeeding. Just as the pumping is not exclusive to working

moms, neither is bottle feeding a baby pumped breast milk; yet, this is a concern for moms that must pump in order to remain in moderate naturalism. Initially, parents are warned against offering bottles to their newborns for fear of newborns rejecting the breast in favor of the bottle's nipple – nipple confusion. Like in most other circumstances, *Parenting* has the answer to using bottles in a non-threatening way. After the baby 1) “latches on easily at every feeding,” 2) is “gaining weight,” and 3) nipple soreness has dissipated, *Parenting* advises to “bring out the bottle sooner rather than later, as long as all three indicators are in place” (Clark, 2002, p. 161). Bottles may be filled with breast milk or formula. Formula supplementation, referred to as “combo feeding,” is a common practice that embodies both a great relief and help to mothers and their children as well as the foremost threat to continued breastfeeding. *Parenting* provides advice from the editors of *Babytalk* (2012),

But while we at *Babytalk* really do agree that breast milk is the gold standard in infant nutrition, we also recognize there's no one way to feed a baby. In fact, breastfeeding some of the time and bottle-feeding the rest – what we call “doing the combo” – can be an ideal choice for many moms (para. 4).

While needs to supplement include nutritional needs of premies, poor latch combined with failure to thrive, insufficient milk supply, exhaustion, and difficulty maintaining breastfeeding, especially due to the return to work, the general advice is to combo feed so as to not cease breastfeeding altogether. Supplementation superficially challenges maternal instruction that demands exclusive breastfeeding but does not challenge the message that breast milk is best.

Many women think they must wean completely if they can't nurse at every feeding or if they don't produce enough breast milk to fill a bottle. In fact, you should try to continue breastfeeding and supplement with formula, since even a small amount of breast milk can be beneficial to a baby's health (Michels, 2000, p. 176).

Supplementation promises flexibility through combo feeding but retains breast milk as the gold standard. Following this logic, mothers may risk judgment or maternal guilt by combo feeding in order to accommodate the schedule demands associated with the return to work.

While advice for pumping at work centers on planning, advice for breastfeeding in public centers on comfort and discretion. The public scene carries with it onlookers with a variety of opinions on breastfeeding causing mothers to feel exposed and vulnerable to public scrutiny. Celebrity moms, like Pink and Angelina Jolie, featured breastfeeding in parenting magazines, make breastfeeding in public appear normal. For moms with greater levels of insecurity and concern over nursing their baby in restaurants, malls, and parks, Neifert with *Parenting* has a few tips:

But with practice, you can become confident feeding your baby almost anywhere. Some tips: Opt for a bra with a release mechanism that's easy to manipulate with a single hand. Put a receiving blanket or nursing shawl over your shoulder to shield your baby from public view, or use a sling, which lets your newborn breastfeed out of sight while you carry him. Wear two-piece outfits... (Neifert, 2012a).

Booby traps can trip mothers up in their attempts to fulfill pediatric nutrition instruction, but the texts that prescribe breastfeeding as optimal from birth through 4-6 months are the same texts that prescribe the strategies and tips to overcome any conflict to the breastfeeding plot. What are the implications for mothers that either choose to or are not able to overcome conflicts to the breastfeeding plot? This question will be explored in Chapter IV. Overall, mothers are positioned as problem solvers, and authoritative texts along with the medical knowledge and experts cited within the texts are positioned as the supporting characters. As problem solvers, mothers are assumed to have agency - ability to control the maternal body, the child, the breastfeeding scene, and contextual limitations. This characterization of motherhood persists throughout the birth through 4-6 month period.

Overall, the birth through 4-6 month period within moderate naturalism represents a crucial time in the chronology of a baby's development of nutritional habits and health. Through instructional texts, mothers are led to believe that they have control over the decisions that can reduce their child's risk of developing a wide array of diseases and health problems, enhance their child's health, and enhance maternal health. To avoid risks and maximize health gains, mothers, particularly, are singled out in the narrative of moderate naturalism and instructed to breastfeed, overcome obstacles to breastfeeding, and act in accordance with what is most healthy for her child. With little attention to contextual issues like SES, ethnic background, or familial composition, mothers are positioned in an individualistic framework of decision making and are characterized as problem solvers with the knowledge and social support capable to enact

the nutrition enhancement and risk aversive project of breastfeeding. Transitioning to the next time period in the narrative, breastfeeding continues alongside the introduction of solid foods further emphasizing maternal responsibility.

Four-Six Months through One Year: Introduction of Solid Foods

Introduce Solid Foods at 4-6 Months

The introduction of solid foods at 4-6 months is a new endeavor for parents as they build up to three meals per day for their children by age one. This change in plot and sequence brings about an array of decisions related to solid food introduction including which foods to feed first, how to order foods, which foods are safest and healthiest, which foods will the child eat, and how to feed, prepare, and store foods safely. Solid food concerns center around the child's willingness to eat and the provision of nutritious and safe meals.

Every relative and her neighbor has advice, much of [it] contradictory (start with vegetables versus start with fruits, babies need teeth for table food versus no, they don't). And everyone seems certain she's right. Plus, the new[s] is so full of nutritional directives that it can be dizzying. We feel judged as parents based on the eating habits of our children, and we want so much for them to eat well and grow well; it's hard not to feel overwhelmed trying to figure out how best to feed them (McCarthy, 2004, p. 90).

Parents often express anxiety about their children's Cheerios intake versus their willingness to eat mashed sweet potatoes. Personally, I can recall a moment of horror as my sixth-month old son appeared to have an orange tint to his skin only to find out his

favorite foods – peaches, carrots, and sweet potatoes introduced in that order for a 9 day rotation – were turning him a hue similar to the foods he was eating. The phrase, “You are what you eat,” took on a whole new meaning in my household. The newness of solid foods and questions that arise as parents feed their 4-6 month old are answered in pediatric nutrition instructional texts.

“You’re the gatekeeper. You have to offer her a variety of healthy foods,” and then, simply trust the child “to eat what she needs” (Tilsner, 1999, p. 121). As gatekeepers of nutrition, parents are instructed to prop their baby in an appropriate seat (e.g. highchair, infant seat, or stroller), use bowls and rubber tipped or plastic spoons with food on the end, place food in baby’s mouth by opening their own mouths to encourage mimicking, and scrape dribbles off face to begin process again (Henry, 1999). Usually, parents are instructed to begin by mixing cereal with breast milk or formula followed by single ingredient foods the consistency that the child can easily swallow (McCarthy, 2004). As children eat more, parents are warned that their preferences will ebb and flow.

To accommodate an evolving palate, *Parenting* encourages parents to: “Let him chose what he wants to eat, as long as he’s presented with appropriately nutritious options” (Banin, 2005, p. 93), but parents are warned, “It takes children an average of fourteen times before they’ll accept a new food, so don’t give up” (p. 95). *Parenting* tells readers that introducing solid foods “is not astrophysics,” and goes on to say, “And even if you goof once or twice – say, give him fruit before rice cereal – nothing bad is likely to happen. Still by sticking to the right timing and sequence of your baby’s first

‘real’ foods, you can improve his nutrition and health” (McCarthy, 2006, p. 132.).

Regardless of caveats like these to calm the anxieties of parents transitioning into the unknowns of solid foods, nutritional texts demarcate good parents as knowledgeable about the associated short and long-term health outcomes with 1) introducing solid foods too early, 2) not waiting the recommended three days in between each new food, 3) not discarding or storing foods properly, and 4) not avoiding foods deemed unsafe.

Do Not Introduce Solids Too Early. There is not widespread agreement as to whether a parent should begin introducing solids at four months or wait until six months. Therefore, parents are to wait until their children demonstrate the readiness signs. A baby should be able to steady his head, control his upper body, sit in a highchair without assistance, and show an interest in food such as mimicking mouth movements or grabbing at food (Hochwald, 2006; Sears, 2001). Children exhibiting readiness signs can begin on either cereals or pureed fruits and vegetables.⁶ Parents who deviate from this instruction by introducing solids prior to 4 months increase their children’s exposure to two risks: health risks and negative perceptions of eating. For example, health risks of early introduction of solids include food allergies and choking. *Parenting* warns,

Introducing solids before she’s 4 months old could actually be harmful to her health: Since infants haven’t yet developed the jaw and throat muscles needed for gumming and swallowing food, they are at risk of gagging. They also don’t

⁶ The choice to introduce cereals or pureed fruits and vegetables before one another is not highly controversial, but it is of note that recommendations vary as to which one to start. For example, Black (2001) says, “TRY RICE CEREAL FIRST. It’s the easiest to digest” (p. 2001). Dr. McCarthy recommends in her Q&A article, “Keep in mind, too, that some experts now believe that fruits and vegetables (either mashed, strained, or pureed) should be a baby’s first foods instead of cereal...” (2006, p. 40, emphasis in original).

produce the intestinal enzymes needed to digest anything other than breast milk or formula... (Parenting, 2000, p. 222).

Trying to force food into the baby's mouth may cause gagging and choking, subsequently causing the baby to associate danger and displeasure with eating. When parents observe signs of readiness, they may begin introducing foods like mashed bananas and rice cereal. Parents must remember, "The most important goal is to encourage the development of a healthy attitude toward food" (Sears, 2001).

To shape the child's perceptions about nourishment, instruction indicates that parents may need to reshape their perceptions about nourishment. Tilsner (1999) explains that babies should learn that eating is a "pleasurable, social activity" (p. 119). By approaching mealtime as experimental and fun, parents are more likely to interest their children in healthy solid foods. As children get more and more teeth during the 4-6 month and one-year markers, parents are able to offer vegetables with "kid appeal." To do so, pediatrician Claire McCarthy (2004) suggests, "Creativity can mean playfulness – broccoli forests..." (p. 91), and Marisa Maeyama (2004) expounds with this bit of advice, "Easy ideas for transforming vegetables so they're pretty on the plate and fun to eat: scoop mashed sweet potatoes into orbs with a melon baller..." (p. 320). Parents are motivated by 1) a concern for healthy solid food options introduced at the right developmental marker to avoid food allergies, choking, and poor eating attitudes and 2) a pursuit of playful, creative food presentation, texture, and delivery.

Wait Three Days Between Each New Food Introduction. Second, parents who fail to wait the recommended three days in between each new

mashed/strained/pureed food risk the development or failed recognition of food allergies (Black, 2001; Hochwald, 2006). For moderate naturalism, jarred baby foods including non-organic or organic and homemade foods are acceptable. The priority is timing and safety rather than pure naturalism. Hochwald (2006) instructs, “After five days [following rice cereal], introduce jarred vegetables, fruits, and meat. Each time you offer a new food, wait a few days before trying another to make sure he isn’t allergic to it.” To determine the development of food allergies, parents are instructed to “monitor your baby to make sure he doesn’t develop a rash or an upset stomach – signs of an allergy” (Barnett, 2000, p. 84). The likely allergenic food is the newest food introduced. If parents introduce multiple foods at once, it may be difficult to determine the allergenic food.

Prepare, Store, and Discard Baby Food Properly. Third, parents who do not prepare food safely, store baby food properly, or discard leftover food that has been contaminated by bacteria transported from the baby’s mouth via the spoon risk the development of illness. To begin, instructional texts present parents with a variety of acceptable baby food choices and combinations including non-organic and organic commercial baby food, homemade baby food retailers online, and homemade baby food in the home. The master narrative assumes that parents are motivated by well-being of child over lifestyle choices, and therefore, parents aim to select baby food that is safest and healthiest for their children. Other noted concerns include “hot spots” from heating food in the microwave (Sansone, 2005, p. 42), nitrates in homemade foods from certain vegetables like carrots and spinach (McCarthy, 2012), bacteria in baby food jars due to

spoon feeding from the jar (Black, 2001), and storing open baby food containers in a refrigerator (Murkoff & Mazel, 2010). Attending to these safety concerns should ensure that parents are safely feeding their children.

Do Not Introduce Age Inappropriate Foods. Fourth, parents should not feed babies solids difficult to chew given the tooth development of their child, solids difficult to digest given the development of the stomach, or solids with high rates of food allergies. By avoiding such foods, parents may reduce risks of short-term problems related to choking and digestion, and long-term problems with food allergies. For example, parents are instructed to withhold foods, like nuts, that are difficult to chew and swallow given the specific tooth development and chewing ability of their children. Parents are the gatekeepers of food and carefully monitor what is given to their children and how their children react to it. Connolly (2004) writes, “Being a mom means being ever watchful – of a child choking on a carrot, falling off the monkey bars, you name it” (p. 149). However, choking hazards are “no, no” foods for kids under four years of age. Foods that pose choking hazards include nuts and seeds, popcorn, raw vegetables, hard or sticky candy, chewing gum, whole grapes, whole cherries, or chunky peanut butter (McCarthy, 2012). Parents are also warned against feeding their children foods with high rates of allergies, especially if there is a family history of asthma or allergies. One parent with allergies can increase baby’s risk “up to 20 to 30 percent,” and two parents with allergies can increase baby’s risk up to “40 to 70 percent” (McCarthy, 2006). Foods that are high allergenic include peanuts, tree nuts, cow’s milk, shellfish, wheat,

and soy. While not all parents may deem it appropriate to avoid wheat and soy from 4-6 to 12 months, the other foods are traditionally banned from a baby's solid food diet.

A final note about food allergies and digestion: recommendations change over time, necessitating good parents to be well-informed parents. For example, commercial baby food solids typically contain zero spices. Historically, parents have been instructed to avoid spicy foods for fear that spices would interfere with digestion and/or cause allergic reactions. However, pediatric nutrition recommendations change over time. Shins (2008) tells *Parenting* readers to, "Spice it up!" with such flavors as ginger and mint (p. 138). Through continued information seeking about solid food recommendations and adherence to safety guidelines, mothers are poised to hit the moving target of solid food introduction.

Juice and Vitamins. The 4-6 month marker may also mean that parents begin giving their children vitamins and 4 -6 ounces of 100% fruit juice. The instructional texts present this advice in a straightforward way with little variations on acceptability. In terms of juice, parents must "wait until she's about 6 months old" and stick to 4-6 ounces to avoid "diarrhea or excessive weight gain" (McCarthy, 2003). Before introducing solids or juice, parents need not consult a pediatrician as long as they follow guidelines. However, before adding a vitamin or supplement, parents are directed to consult a pediatrician, as most vitamin and supplement regimens are child-specific. On average, children do not need supplements between 4-6 and 12 months, but some conditions, like an iron deficiency, may merit intervention. For example, some children need additional iron as they get older because they are consuming less in breast milk or

formula. An iron deficiency affects about 11% of children between 4-6 and 12 months. Generally, the emphasis during 4-6 months and 12 months resides with solid foods rather than juice or vitamins, specifically constructing the maternal role as risk reducer. The mother functions as the nutritional gatekeeper protecting her child from developing food allergies, negative perceptions of food, and exposure to safety hazards like choking.

Conclusion

Once you've mastered the practical stuff, feeding your baby can be a wonderful bonding time, relaxing and rejuvenating for both of you. So hold her close and enjoy the calm – it won't be long before she's wearing sauce all over her face and pitching peas at the dog (McCarthy, 2003).

The “practical stuff” is often technical and unknown territory for parents, and as evidenced in this chapter, information seeking and social support are important for moderate naturalism's aims and actions to be implemented. The plot centers on actions motivated by a maternal sense of responsibility for children's health and safety. More pointedly, parents begin planning for the safest and healthiest feeding method during pregnancy by educating themselves about breastfeeding and the consequences of their parental feeding choices. Mothers embody the role as nutrition decision maker for the fetus, an empowering yet weighty responsibility consistent with neoliberal, postfeminist constructions of motherhood (Dubriwny, 2013).

The pediatric nutrition instructional discourse from birth through 12 months constructs expectations that babies will be breastfed, with limited deviation from this plot, and that mothers will overcome any challenge to the breastfeeding plot. In other

words, mothers add problem solver to their decision-making role in order to maintain the decision to breastfeed in the wake of conflicts to plot. Breastfeeding becomes a risk aversion and health enhancement project for mothers to protect their children from health threats and facilitate healthy development. This project is highly individualized in the sense that mothers seek out expert advice as to overcome breastfeeding challenges pertaining to herself and child while broader social impediments to breastfeeding like negative perceptions of public breastfeeding or short maternity leaves are dismissed. Conflicts, framed as breastfeeding challenges, are described as adversarial and, subsequently, cast scenes like work and public, other characters including baby, mother's body, and socio-emotional/perceptual barriers (e.g. breasts are sexual not functional) in opposition to the goals of the breastfeeding mom.

Armed with information and social support, mom is expected to overcome conflict and continue breastfeeding, even if only part-time. Instructional texts and medical experts' roles are etched into the narrative as sources of informational and social support for feeding so that plot complications can be met with the right narrative action and provide self-efficacy to the maternal problem solver. Despite lactivist overtones, moderate naturalism is a relatively apolitical narrative. Although lip service is paid to structural and cultural barriers to breastfeeding, there is no agenda set forth to change these barriers. Similarly, Johnson (2004) argues that Premenstrual Dysphoric Disorder advertisements adopt an "individualistic framework" that reinforces postfeminist ideologies of women coming "to see their own experiences reflected in a scientific discourse that specifies an individual remedy to shared problems" (p. 341). Instead of

using challenges to breastfeeding as an opportunity to critique culture and decenter the mother's responsibility for successful breastfeeding, moderate naturalism instruction responds by bolstering traditional gender expectations of women to perform child care, specifically nutritional care, and resourcefully apply technical knowledge to self-govern her lactating body. Mother essentially become nutritionists and lactation specialists, giving their bodies over to the risk averse, health-enhancing project of breastfeeding. This characterization of mother keeps her in her proverbial place within the home and out of public politics, which has the power to shift individualized frameworks to cooperative frameworks.

Once 4-6 months rolls around, parents have a new responsibility – the introduction of solid foods. Timing of this stage depends on the physical development and interest of the child. Parents must determine during months 4, 5, and 6 the best time to offer solids to their child, what types of solids to introduce first (e.g. cereal, fruit, or vegetable), whether or not they will use commercial baby foods or make their own, and whether or not they will introduce 100% fruit juice or offer their children mashed/pureed fruits. Moderate naturalism's plot limits legitimate choices from birth through 4-6 months to breastfeeding or limited combo feeding. However, moderate naturalism presents a greater range of legitimate choices from 4-6 months through 12 months. Parents are encouraged to experiment with safe and nutritious foods making mealtime fun and adventurous for parent and child but to continue to maintain motivations for safety and optimal health by carefully monitoring their children's reactions to food. Despite increased flexibility in this chronological period, there are more decisions to

make regarding foods and, subsequently, more risks associated with feeding. As the nutritional decision makers or gatekeepers, mothers remain the targets of feeding instruction and retain the primary responsibility as risk reducer for their children's transition into solids. These texts hone in on the mother's role in establishing nutritional patterns that will enhance short and long-term health, more specifically prevent susceptibility to diabetes and obesity. Yet, larger cultural issues are neglected such as sedentary lifestyles due to high media consumption or fast food convenience and poor quality. Attention to larger cultural issues presupposes that the mother is not fully responsible as the gatekeeper of nutrition and would call for cooperative action to make substantive changes. Once more, there is a reoccurring postfeminist theme related to individualism that imposes maternal responsibility for child health outcomes.

As Chapter III comes to a close, I return to the story that began this chapter. Admittedly, I was proud that my 11-month old son was open to new tastes and ate appropriate amounts at meal time, but I also knew from experience that he could just as easily turn his nose up at the food I offered and shut his lips refusing to eat it. To be perfectly honest, Daniel had his fair share of prepackaged pureed and finger baby foods, and it is likely that the following week Daniel refused the spaghetti he loved that evening with our friends. With that said, Daniel was also interested in what his two older brothers and parents were eating at the table – yes, that includes French fries and pizza. I obliged, hoping that it would encourage him to eat a greater variety of foods and get in the habit of eating what was on his plate rather than asking for special meals. Yet, in all this, there is a big difference between my attitude and practices in feeding my first-born

son and number three. With Daniel as number three, you might say I relaxed a little. When I struggled to run errands, care for two siblings, and breastfeed, I opted to combo feed. When Daniel reached for a slice of pizza, I let him take a bite. And I am certain that had my family witnessed what my friends witnessed when we were a family of three, not five, I would have posed the same questions as my friends did. My friends were within moderate naturalism when it came to solid foods, but I differed in resisting some of the constraints of moderate naturalism's narrative action, though not moderate naturalism's motivations to safely feed children and optimize health benefits. The next chapter explores those narratives that do not fit moderate naturalism by looking at two other approaches to naturalism – strict naturalism and synthetic acceptance.

CHAPTER IV

COUNTER NARRATIVES

As I pieced together the narrative components from pediatric nutrition instruction in Chapter III, I could not help but laugh, cry, and nod “yes” and “no” over the keyboard as I typed. Seeing moderate naturalism developed in instructional texts brought to mind many memories of feeding my three sons during these time periods. The mix of emotions was, in part, due to my varied experiences. For my first son, I was the model moderate naturalist parent. Motivated by concern for safety and optimal health outcomes, I persevered through breastfeeding challenges, including engorgement and pumping at work, in order to primarily breastfeed for the first six months. While I did combo feed a couple of days of the week for one to two feedings during the work-day, I committed to breastfeeding. When he demonstrated the readiness signs for solids, I began with rice cereal followed by vegetables and then fruits on three-day introductory rotations to detect and minimize the development of food allergies. If an expert recommended a particular feeding action, I responded with adherence, trusting the expert.

For my second son, breastfeeding was easier. However, no one told my two-year old that breastfeeding meant mommy needed to give baby attention in 20-minute increments every two hours. He looked at the baby, pointed, and exclaimed, “Baby needs a nap.” That was code for, “Pay attention to me.” Breastfeeding took time and attention, but formula feeding was quick and versatile. Anyone could prepare the bottle and feed the baby. To further complicate matters with the birth of our second son, I was

on maternity leave but my spouse continued working and was unable to assist with entertaining the older child during feedings. When I returned to work, I had difficulty asserting myself to request a separate office or space to pump, or to ask students to leave for my pumping breaks. The thought of coworkers or students knowing I had a breast pump hooked to my chest was cause for my face to turn at least 10 shades of red. I made it through the Spring semester of teaching by combo feeding. To be honest, bottles and formula just made life easier. When it came time for solids, I offered more and more mashed and pureed table foods, –spices and mixed ingredients to boot. For my third son, I did much of the same improvising to fit the situational demands of feeding, parenting, and working(?), while I broke a few more moderate naturalist rules as to what foods should be introduced. Funny enough, the American Academy of Pediatrics now agrees with a number of the ad hoc decisions I made, like giving an 11-month old scrambled eggs. Did I just get lazy as a moderate naturalist, or is it possible that I was performing a counter narrative?

Chapter III reviewed the construction of the master pediatric nutrition narrative, moderate naturalism. Moderate naturalism conflates parenting with mothering by focusing on maternal decision making related to breastfeeding, problem solving related to exclusive breastfeeding, and gatekeeping of food as solids are introduced. However, moderate naturalism is not the only pediatric nutrition narrative presented in instructional texts, just as it is not the only narrative enacted by parents. Instructional texts are rife with fragments of counter narratives that I fit together in this chapter to

construct two counter narratives. Chapter IV is positioned to answer the second research question:

RQ2: In what ways are the master narrative and its plot of parenting contested and transformed in pediatric instructional messages?

Chapter IV focuses on two counter narratives presented in pediatric nutrition instructional texts – *synthetic acceptance* and *strict naturalism*.

Synthetic acceptance is a pediatric nutrition narrative in dialogue with moderate naturalism. The ways in which moderate naturalism fails to acknowledge the problematics of breastfeeding exclusivity, synthetic acceptance gives voice to these breastfeeding problems and, thus, counters the characterization of good mothering as the breastfeeding mother. As a nutrition narrative, synthetic acceptance broadens the scope of feeding methods and products available to mothers by permitting non-organic, commercially processed products. *Strict naturalism* is also a pediatric nutrition narrative in dialogue with moderate naturalism's insistence to breastfeed, but situates itself in an alternative narrative space by dictating the use of organic practices and products from birth onward. Whereas moderate naturalism and synthetic acceptance messages focus on the chronological period of birth through 4-6 months, strict naturalism focuses on the 4-6 through 12-month period. Strict naturalism emphasizes making organic baby food. The remainder of Chapter IV is divided into two major sections beginning with synthetic acceptance and followed by strict naturalism. Chapter IV follows a similar pattern as laid out in Chapter III by overviewing each counter narrative and describing their narrative features during three key time periods: pregnancy, birth through 4-6 months,

and 4-6 months through one year. At the end of Chapter IV, a conclusion section highlights the relationships between the master and counter narratives and draws attention to important implications.

Synthetic Acceptance

The narrative labeled synthetic acceptance is a nutrition narrative that accepts synthetic, non-organic milk and food products as safe and healthy for child development. The narrative generally characterizes parents, and mothers particularly, as motivated by high degrees of control over the feeding process, the product being consumed, and the outcome. For a moment, imagine the home of a baby reared in the synthetic acceptance narrative plot and sequence. It is likely that mom's reading materials are similar to that of the moderate naturalist. Therefore, it would be commonplace to find a copy of *What to Expect the First Year* by a rocking chair or to have parenting.com or babycenter.com up on a tablet at the kitchen table. However, the synthetic acceptance kitchen would be strewn with bottle paraphernalia. Since the primary nutritional source for synthetic acceptance from birth through 4-6 months is formula prepared with distilled or tap water in a baby bottle, this kitchen would be bursting at the seams with different-sized nipples and bottles, bottle brushes, and the like. Whereas, the moderate naturalist's kitchen may have no evidence of infant feeding due to effective nursing or may have breast pump paraphilia mixed in with the bottles. Powdered formula, likely in a canister, is on the synthetic acceptance counter or in a cabinet within reach of bottle and water for easy preparation. At the 4-6 month marker, the synthetic acceptance pantry is fully stocked with stage 1, commercially processed baby foods and rice cereal. Peaches, pears, sweet

potatoes, and squash are likely staples in this pantry. There may even be a Sippy cup with 4-6 ounces of 100% juice at this point keeping a bottle company on a counter.

This tour of a synthetic acceptance home may reveal basic differences between prescribed feeding practices across nutritional narratives, but a closer reading of the synthetic acceptance narrative reveals a struggle between a pseudo-counter narrative voice and full-fledged struggle over meaning with the master narrative. I use the term pseudo-counter narrative to help explain how synthetic acceptance seems to offer mothers a choice as to how they will feed their baby in the first 4-6 months, expanding the diversity of feeding practices available to mothers to fit their needs. In the synthetic acceptance narrative, formula feeding is the norm. However, I argue that synthetic acceptance lacks textual space for development, that the texts in which it is interwoven undermine its legitimacy, and that maternal experiences within synthetic acceptance messages pressure mothers to mourn the loss or inability to breastfeed and justify their reasons for not breastfeeding. Synthetic acceptance, in turn, reproduces the “breast is best” ideology and characterizes formula feeding mothers as merely acceptable if they demonstrate appropriate guilt and justifications for their choices. Therefore, the counter narrative possibilities of synthetic acceptance remain under-realized. The following section contextualizes these arguments by overviewing the characterizations, actions, conflicts to plot, and sequencing that set synthetic acceptance apart as a narrative. Synthetic acceptance is constructed using texts and messages within texts referenced in Chapter II that explicitly align with the tenets of synthetic acceptance nutritional practices. The Moms Feeding Freedom blog is one of the few exclusively synthetic

acceptance texts. However, general baby care texts contain fragments of synthetic acceptance narration and are drawn upon within the following subsections.

Pregnancy: Nutritional Preparation

As in each of the narratives, master and counter alike, pregnancy is an important chronological period for parental education about the nutritional choices available to them to feed their newborn. Moderate naturalism demonstrates the wealth of information that parents receive about breastfeeding during pregnancy in order to shape their decision making to breastfeed prior to labor and delivery. In reference to the pregnancy section in Chapter III, instructional texts delineate one acceptable choice for good parenting – breastfeeding. Pediatric nutrition instruction assumes that parents intend to breastfeeding and, thus, educate themselves and make plans to ensure that breastfeeding is initiated postpartum. Formula feeding is positioned as a nutritious, safe, but inferior choice for parents within synthetic acceptance. Parents are primarily trained and instructed on breastfeeding during pregnancy. Instructional texts often begin feeding advice by explaining the benefits of breastfeeding, which take more pages and include more benefits and, then, describe the benefits or advantages of formula feeding. In *What to Expect the First Year*, Murkoff and Mazel (2010) list the following benefits to formula feeding: longer satisfaction for baby, easy monitoring of intake, more freedom, fewer demands, more participation for father, more participation for older siblings, no interference with fashion, less restriction on birth control methods, fewer dietary demands/restrictions, less embarrassment for the modest, and potentially, more sexual intercourse. Despite the description of benefits such as these, formula feeding messages

in the synthetic acceptance narrative are overshadowed and minimized by breastfeeding messages. For these reasons, synthetic acceptance messages interwoven into moderate naturalist texts may allude to the need to formula feed but reproduce “breast is the best” first choice. It is likely that parents perceive synthetic acceptance as a second and inferior choice; that is, if moderate naturalism does not work out as option A, then synthetic acceptance will be there as option B. The next chronological period in synthetic acceptance further discusses synthetic acceptance and clarifies how parents are characterized about their choice to formula feed.

Birth through 4-6 Months

The feeding practice that sets synthetic acceptance apart from the other narratives is formula feeding from birth through 4-6 months. Synthetic acceptance asserts that formula feeding is a legitimate choice for infant nutrition. “Don’t forget, infant formula is loaded with nutrients, fats, and proteins that mimic breast milk. No food is held to a higher standard by the FDA than formula. So rest easy” (Kahn, 19 January 2012, para. 4). Resting assured that formula is a safe and nutritious choice for their children, parents adhering to synthetic acceptance achieve high degrees of control over feeding through formula. Of note is the entry point of parents into synthetic acceptance. Because pediatric nutrition instruction is imbued with “breast is best” ideologies, parents often shift from moderate naturalism to synthetic acceptance. Before further exploring the synthetic acceptance themes related to formula selection, safety, and guilt, I need to clarify how instructional texts construct shifts to the synthetic acceptance narrative.

Despite overwhelming pressure to breastfeed and identify with moderate naturalism, breastfeeding is not initiated or continued for a variety of reasons including but not limited to: insufficient milk supply, maternal self-care (e.g. taking a prescription drug prohibited for breastfeeding mothers), diseases risks (e.g. HIV), poor latch or inability to latch, inverted nipples, uncooperative workplace, lack of social support, exhaustion, discomfort, and/or inexperience (Crane, Heyworth, & Clower, 2012; Murkoff & Mazell, 2010; Skinner, 2003/2004). Texts often use a mom story that describes her best efforts to breastfeed or laments her inability to breastfeed in order to explain the shift to synthetic acceptance. In many ways, these shifts are attributed as mothers' failed attempts to address breastfeeding challenges (reference Appendix D entitled Breastfeeding Challenges). What's more, the shift to formula feeding within mom stories focuses on the maternal role and responsibility for enacting pediatric nutrition decisions rather than drawing attention to the right to formula feed or the quality of formula. In Karen O'Shea's story featured in *Parenting*, her shift to formula feeding and synthetic acceptance was the result of a return to work and failing to "map out a strategy" (D'Angelo, 2001, p. 119). Kim Kain's mom story is drastically different. Regardless of her breastfeeding efforts (e.g. elimination diet, change holds), breastfeeding resulted in her child in "a fit of tears" every time (p. 120). Most of these mom stories end in a description of their mixed emotions of guilt, relief, and reassurance. To better understand the synthetic acceptance narrative as laid out in pediatric nutrition instruction, the following subsections identify a trifold focus on consumer choice, safety, and guilt. These themes highlight how parental control over

formula type, formula preparation, and nutrition contribute to reassurances of their good parenting; while a lack of control over social perceptions and stigma related to formula feeding contribute to feelings of guilt and questioning of their good parenting.

Consumer Choice and Formula Feeding. One of the most important decisions that synthetic acceptance parents make is selecting a formula that best suits the needs of their child. Instruction within this narrative characterizes parents as in control of matching the formula type to the child's needs. For most children, cow's-milk protein-based formula is ideal, most closely mimics breast milk, and accounts for 80% of the formula sold (Shelov, 2010). However, vegan families may elect a soy-based formula (Geddes, 2004), and families, whose children have a true cow's-milk intolerance (2% of children), should consult their pediatrician about hydrolysate formula (Feld, 2008). More specialized formulas are available such as amino-based, elemental, formulas for preemies, and thicker formulas for babies with reflux (Shelov, 2010). Formula enrichments include iron (standard), DHA and AHA, and probiotics (Andrik, 2007; Hermann, 2001; Howchwald, 2008). The overarching message related to consumer behavior and infant formula stresses the degree of control that parents can exercise over their child's only source of nutrition from birth through 4-6 months. The mother imaged in totalizing motherhood is reimagined in synthetic acceptance as using formula as her means to control every detail in a calculable way (Hausman, 2003). With breast milk, parents do not know how much milk is being consumed at each feeding and can only control taste and ingredients through elimination dieting, but formula affords parents the ability to know exactly what and how much their children are drinking at each feeding.

Consequentially, formula-matching and control function as challenges to single dimensional constructions of good mothers as breastfeeding mothers. Synthetic acceptance demonstrates how good mothers can enact tenets of totalizing motherhood (see review in Chapter 1) through formula feeding as well.

Safety and Formula Feeding. Synthetic acceptance instruction also emphasizes safety concerns and protocol in the preparation and storage of formula and bottle feeding. Safety instruction centers on 1) cleanliness of the environment and utensils and 2) concentration of the formula per ounces of water. First, formula feeding requires containers of formula, utensils for mixing, nipples, and bottles, thus increasing the opportunity for bacteria and germs to contaminate the baby's sole source of nutrition for her first 4-6 months of life. Parents are warned to not get lazy and "inadvertently skip a step" (Kahn, 2 February 2012, para. 6). Instead, instruction recommends that parents "put a list of instructions somewhere in the kitchen where everyone can see it – maybe on the refrigerator" (Kahn, 2 February 2012, para. 6). These instructions should establish cleanliness standards that protect the baby. Foregrounding scene and tools, synthetic acceptance insists on a clean and sterile environment.

Keep it clean. Before using a new bottle, unscrew the nipple, pop it out of the ring, and sterilize each part or boil in water for five to ten minutes. No need to sterilize after each feeding – just put the bottle in the dishwasher or wash with hot, sudsy water, with a bottle brush to scrub away milk residue (Papandrea, 2008, p. 116).

Clean bottles reduce the risk of bacterial and viral infections that can be deadly for newborns' immune systems. Other ways to decrease contamination for bottle feeding include wiping the tops of formula containers before opening, boiling water for only 2 minutes to rid of germs, preparing new bottles for each feeding, and discarding leftover formula in a bottle (Coutts, 2000).

Second, synthetic acceptance instructs parents that directions specifying formula ratio to water must be adhered to. Overall safety of the child may be risked if formula is diluted and watered down, subsequently causing synthetic acceptance instruction to emphasize the importance of following formula preparation instructions on the canisters/bottles. There are a number of reasons that a parent may water down formula. As in this study, some parents may dilute formula in order to stretch out the supply due to low income “ (Kahn, 26 January 2012), while others dilute formula because they have been told it will help constipation or prevent diarrhea. Diluting formula and class implications that necessitate formula stretching will resurface in the concluding section.

Synthetic acceptance instruction related to a clean environment and formula instructions adherence further reinforces characterizations of parental control. In other words, by following sets of safety instructions, parents are able to ensure that the food preparation environment and food itself result in risk aversion and health enhancement, a motivation shared by moderate naturalism, but achieved through formula feeding. Whereas consumer choice and formula feeding draws attention to parental control over the product and quantity consumed during feedings (e.g. “I don't know how much breast

milk my baby is getting, but I can measure formula.”), safety and formula feeding draws attention to parental control over the scene as well.

Guilt and Formula Feeding. Parents are primed that formula feeding leads to feelings of guilt as they read about this theme during pregnancy, and inevitably, the theme resurfaces as a concern during the implementation of formula feeding practices. As illustrated in Appendix F Formula Feeding Guilt, guilt is described in different ways but, ultimately, these descriptions point to feelings of personal and social judgment underscored by “breast is best” discourse. Guilt for formula feeding is attributed to judgment from experts and other mothers, comparison of one’s own feeding method to what instructional texts advocate, and (self?) perceptions of not trying hard enough to breastfeed (Barston, 2013; Ruddy, 2013; Stanley, 2000). To address formula feeding-related guilt, synthetic acceptance texts reassure mothers through their own voices and that of experts that formula feeding is a safe and healthy option, and provide social support for mothers experiencing guilt. Reassuring messages reinforce the safety and nutrition of formula and draw attention to overstated benefits of breastfeeding. Some of these reassuring messages directly instruct mothers not to feel guilty. “If you’ve chosen to use formula, don’t feel guilty. Know that you’re giving your baby a great start in life” (Kahn, 19 January 2012, para. 4). “There should be no guilt” (Kahn, 11 August 2011, para. 4), and “[D]on’t shower yourself in guilt” (Krych et al., 2012, p. 43). Whether direct or indirect, reassuring messages are aimed at promoting the self-efficacy of mothers. These messages affirm formula’s nutritional value but also affirm the mother’s and other caretakers’ abilities to decide what is best for the family regardless of how

others may respond. Mothers are told, “It’s easy to let guilt get to you. But don’t. No one else knows your family like you do” (Kahn, 28 July 2011, para. 3).

In order to further assist mothers whose feeding practices fit within synthetic acceptance, texts associated with interactive websites host discussion boards, and non-interactive texts feature feeding stories to promote a sense of community and acceptance surrounding formula feeding. The Baby Center resource website has discussion posts begun by mothers on topics of their concern, seeking out social support from other mothers. In the formula feeding section, a number of mothers reach out to one another because of guilt and/or judgment over formula feeding. For example, in the discussion thread entitled, “Looking For Some Support and Guidance,” one poster writes, “Don’t let ANYONE judge you for making the right decision for yourself and your family. FF [formula feeding] does NOT make you a bad mother or a failure in any way” (Community.babycenter.com, 2013, para. 4). In less interactive texts (e.g. blog posts, articles, etc...), synthetic acceptance stories are featured in order to demonstrate good parenting, and more specifically good mothering, is not exclusive to breastfeeding.

One of the recognizable difficulties of constructing the synthetic acceptance counter narrative, that seemingly embraces formula feeding as a legitimate form of nutrition, is that the majority of reassuring formula feeding stories begin as moderate naturalist stories. Perusing through the Fearless Formula Feeding (FFF) blog by Susan Barston and reading the reposted FFF stories from Facebook posts reveals that most mothers represented on the site have adopted formula feeding because of self-described disappointing or failed breastfeeding. For these mothers, breastfeeding was a chaotic

time filled with uncertainty about nutritional sustenance, failure, and self-doubt. Formula restored control for these mothers, but it came with a price – guilt. This is a reoccurring theme. One poster questions this theme with her formula-from-birth story and satisfaction as a mother, “I simply cannot fathom why I’m supposed to feel guilty about” formula feeding (Fearlessformulafeeder.com, 27 April 2013, para. 20). While this fearless formula feeder has fully embraced the practices of synthetic acceptance, the instructional texts that construct this counter narrative along with the storied communication in interactive and less interactive texts demonstrates that mothers, who identify with synthetic acceptance, struggle to manage the mix of emotions, especially guilt, associated with enacting a counter narrative. Yet, this emotional struggle becomes integrated into the performance of good mothering in synthetic acceptance. Good formula feeding mothers are characterized as constrained in their feeding decision making, wrought with guilt over the shift to formula, and victimized by a moderate naturalist hegemony that unfairly scrutinizes them. Casting formula feeding as a last resort rather than an acceptable choice promotes guilt and undermines messages that legitimize formula.

4-6 Months through 12 Months

Synthetic acceptance instruction stresses the chronological periods of pregnancy through 4-6 months by providing parents with information about formula feeding. With that understanding, the onset of solid foods and juice does bring with it new practices and experiences related to pediatric nutrition. Instruction within synthetic acceptance follows a similar pattern to moderate naturalism by attributing organic and homemade

baby food making to parenting lifestyles rather than nutritional needs. Parents continue to be highly motivated by safety and control, finding that commercial baby foods and juices are safe, nutritious options for their children. By following the chronological sequence recommended in the master narrative, parents incrementally introduce their baby to solids beginning at 4-6 months when their children exhibit developmental markers for food readiness. Starting with rice cereal, foods are introduced in three-day intervals to monitor children for food allergies. Because commercial baby foods are clearly marked by stage, the synthetic acceptance parent is able to easily determine which foods to purchase. Furthermore, since the parent is relying on commercial foods, the parent does not need to worry about exposure to risky foods. Overall, this chronological period mirrors recommendations and constructions of parenting in moderate naturalism. The final months of baby's first year reproduce constructions of parenting, and mothering especially, that emphasize control through adherence to guidelines and safety recommendations.

Synthetic Acceptance Summary

In sum, the counter narrative of synthetic acceptance describes pediatric nutrition that embraces commercially produced, non-organic products as a means of control over the feeding process. Formula feeding represents a way parents can measure and control their children's nutritional intake, conveniently feed their children regardless of scene/context/characters, and create a positive, less stressful feeding environment. Especially if breastfeeding was initiated and could not be sustained or was undesirable, formula feeding represents a way to reestablish a desirable feeding routine.

Nevertheless, formula feeding mothers, in particular, are primed during pregnancy that they should strive to breastfeed and anticipate guilt if their efforts fail. The following critical analysis points out: 1) how synthetic acceptance has the narrative potential to counter essentializing claims about what constitutes good mothering in moderate naturalism, 2) how synthetic acceptance is contained as a counter narrative, and 3) how synthetic acceptance advocacy can help the narrative and the women's experiences represented there within become a legitimate counter narrative.

Synthetic Acceptance: An Antagonism to Moderate Naturalism

In analyzing synthetic acceptance, the overarching narrative difficulty in constructing it as a counter narrative is that synthetic acceptance is not presented on its own merit. Because synthetic acceptance instruction is positioned in dialogue with moderate naturalism and its narrative components are interwoven into moderate naturalist texts, synthetic acceptance does not occupy a separate narrative space. Instead of being able to examine a set of baby care books and articles that generate characterizations of parents, emplotments of what constitutes good parenting, and descriptions of the contextual, scenic, character relationships, and conflicting action of a distinctively synthetic acceptance narrative, I had to sift through moderate naturalist instruction to find nuggets of synthetic acceptance narration (with the exception of two blogs linked to one another, the Moms Feeding Freedom blog and Fearless Formula Feeder blog). The interdependency of synthetic acceptance on moderate naturalist narration ultimately undermines the counter narrative voice of synthetic acceptance.

The degree of interdependency with moderate naturalism gives rise to questioning the status of synthetic acceptance as a counter narrative. Three arguments emerge as to how synthetic acceptance may be more appropriately labeled pseudo-counter narrative. First, synthetic acceptance messages offer an alternative feeding practice – formula feeding – yet fail to question the underlying breastfeeding imperative and science that supports it. This failure can be understood through antagonisms. DeLuca explains how antagonisms function to subvert, disarticulate, and “point to the limit of the dominant hegemonic discourse” (1999, p. 337). In application to moderate naturalism, antagonisms are critical points in the plot of a narrative that provide opportunity to critique the hegemony of the master narrative (Dubriwny, 2010). The following argument explains how the opportunity for critique of moderate naturalism is undermined in synthetic acceptance. In the case of synthetic acceptance, the failure, disinterest, or inability to breastfeed poses an unresolvable conflict in the plot to breastfeed and, thus, represents an antagonism in the master narrative of moderate naturalism. The possibility of critique lies in this conflict. The synthetic acceptance narrative has the potential to question essentializing constructions of motherhood bound up in breastfeeding, especially regarding the construction that breastfeeding is best for all maternal-child(ren) relationships and contexts. There is a stark contrast to mothers’ lived experiences struggling to adhere to breastfeeding standards and the idealized image of breastfeeding as the pinnacle of natural and nurturing. Maternal feeding stories are replete with descriptions about breastfeeding not being best for mother and child. Instead of the contrast between lived and ideal maternal experiences burgeoning into a

dialogue that gives rise to deconstruction of moderate naturalism and biomedical imperatives to breastfeed, the contrast has given way to discussions of maternal guilt. By focusing on maternal guilt, the synthetic acceptance narrative presupposes within their characterizations of motherhood that there is cause for formula feeding guilt.

Furthermore, as Kahn's Moms Feeding Freedom blog and a select few academicians (e.g. Wolf, 2007, 2011) have pointed out, the conclusions of breastfeeding research often overstate the benefits of breastfeeding, fail to engage women's experiences and voices in research design and reporting, and do not explicitly account for other variables that may or may not contribute to a child's health (e.g. cleanliness of the home, multiple caretakers, health literacy of the parents, etc...). The general lack of criticism related to biomedical discourse breastfeeding is consistent with Dubriwny's (2013) conclusions about women's response to the "Go Red" campaign. Women's health campaigns – and arguably children's health campaigns that hold mothers responsible for children's health outcomes – "prompt a near-unquestioning embracing of medical knowledge and technology" (p. 2). Consequently, pediatric instructional texts do not open up space for mothers to contest the power that medical experts, as key characters in these narratives, have been granted to determine what feeding practices constitute good parenting. Instead, discourses of maternal guilt are used to reinforce the power of the medical experts and reproduce moderate naturalist discourse. The popular texts that have the potential, and at times fulfill this potential, to challenge the underlying ideologies of moderate naturalism are texts like the Fearless Formula Feeder and Moms Feeding Freedom blogs. These textual spaces open become avenues for

mothers to be vocal about their lived versus ideal feeding experiences. Furthermore, the language of “fearless” and “freedom” present alternative meanings to the limited constructions of good mothering in moderate naturalism.

Synthetic Acceptance Contained. In turn, antagonisms to the hegemonic master narrative are met with what rhetorical scholars have labeled containment or domestication (Poirot, 2009). Containment rhetoric, in narrative terms, functions to integrate counter narratives into the discursive construction of the master narrative whereby reproducing the master narrative’s system of meaning and power (Anderson, 1999; Dubriwny, forthcoming; Poirot, 2009). Dubriwny and Ramadurai (forthcoming) describes how containment rhetoric functions within the women’s health movement and, more specifically, within the discussion of vaginal births after cesarean (VBAC). Safety discourse is used to contain women’s options regarding birth. In other words, while women espoused autonomy over their bodies, safety discourse limits the scope of what medical experts would deem good or responsible health choices for women to make. This discussion of containment is not unlike the discursive strategies of medical experts in regard to breastfeeding promotion. Generally, containment of the legitimacy of synthetic acceptance is accomplished through explicit promotion of breastfeeding benefits and implicit formula feeding risks. However, once an antagonism to the plot of moderate naturalism occurs, there is opportunity for this containment strategy to be questioned. Nevertheless, what transpires at this juncture is further containment of synthetic acceptance. Containment is achieved by featuring maternal stories of guilt and mourning over the loss or inability to breastfeed. Mothers are portrayed as desperately

trying to overcome obstacles to breastfeeding and plagued with guilt that their best efforts to fulfill moderate naturalism are unrealized. The underlying meaning of this guilt discourse rests in the label *failure*⁷. Instructional texts do not explicitly label mothers, per se, as failures when breastfeeding is not attempted or is ceased. Instead, the term failure is used in reference to breastfeeding as a process, more specifically maternal control over her body, child, and context.

An exemplar of failure terminology pervading discussions of infant feeding can be seen with insufficient milk supply, which is synonymous with “lactation failure.” Lactation failure implicates the maternal body. Cook, Johnson, and Krych (2012) assert that women should “have faith” in their “body’s ability to meet [their] baby’s nutritional needs” (p. 52). Mothers are repeatedly told that their bodies are designed to lactate to meet the fluctuating needs of baby and that they can control lactation through diet, rest, self-care, and pumping. A parenting.com article cites one mom who found it “embarrassing to admit that I can’t do something that is supposed to be a natural thing for a woman to do” (Tusa, 2013, p. 5, para. 2). For each problem presented, the mother is given specific actions to take to restore sufficient lactation and transference of milk.

Despite efforts to tone down the connotation of failure through terminology like “inability to breastfeed” or “inadequate or insufficient milk supply,” the maternal body has eluded the prescribed control of mom in synthetic acceptance. Toning down failure discourse is further complicated by women’s own language. The Fearless Formula Feeder blogger, Susan Barston tells *Parenting* and its readers that she struggled with

⁷ Lactation “failure” is the language that is commonly used to describe both the physiological condition of breast hypoplasia and undiagnosed causes of low milk supply (Davis, 2013).

associated “pain, depression, frustration, craziness, and most of all, failure” with her transition from breastfeeding attempts to formula feeding (Barston, 2013, p. 2, para. 1). Another prominent example of implicit failure messages within guilt discourse is the failure to manage the return to work. A mother may embrace synthetic acceptance as a practical narrative given the scenic demands on time and space – work. The working mother is barraged with breast pumping at work instruction in order to present her with strategies to control her lactating body and continue to breastfeed according to moderate naturalist practices. The mother, who is not disciplined to rise early so that she can pump after the morning feeding or who does not assert herself within the workplace and demand control of her schedule in order to pump, fails to manage the constraints of the work scene and, thus, fails to maintain an adequate milk supply. Overall, guilt discourse within synthetic acceptance emerges in formula feeding education and instruction. Although there are a number of messages that aim to reassure mothers that their guilt is unnecessary, these mothers learn about guilt within this literature, are exposed to mothers’ guilt ridden stories, are invited to join interactive Internet communities discussing guilt, and cannot escape the “breast is best” message (it is stamped on formula canisters). Guilt suggests that there is something to be guilty about – formula feeding – and reproduces constructions of good parenting associated with the master narrative.

Synthetic Acceptance Uncontained. At this juncture, I look to moments within the general pediatric nutrition instructional texts and within exclusive synthetic acceptance texts for ways in which the aforementioned antagonisms may function as

such. DeLuca writes, “antagonisms are differences, limits, in hegemonic discourse that must be articulated as antagonism by groups in order to subvert or disarticulate the hegemonic discourse” (1999, p. 337). The problem resides with their articulation as antagonisms. As discussed above, the guilt-ridden discourse of both nutrition instruction and the mom stories in which it is couched functions to contain antagonisms to “breast is best.” The lead characters in synthetic acceptance are mothers, who inadequately disarticulate the underlying message of the master narrative. Experts sustain mothers’ redemptive performances of guilt by repeatedly exhorting breast milk as the gold standard. However, there are characters on the periphery of this storyline that are advocating for synthetic acceptance’s legitimacy as a pediatric nutrition narrative, for redress within pediatric nutrition instruction, and for broader socio-cultural shifts. The synthetic acceptance activist characters have the potential to become a “group” that “subverts or disarticulate[s]” (DeLuca, 1999, p. 337) the “breast is best” discourse and the narrative of moderate naturalism that propagates it.

In one mother’s words, “It’s time we de-demonize formula” because without it many children would lack the nutritional sustenance to thrive (Stanley, 2000, p. 141). Synthetic acceptance advocacy has identified a number of issues that need wider support, especially amongst mothers, to, in turn, counter moderate naturalism. First, synthetic acceptance advocacy has argued for a greater quantity of formula feeding instruction. In other words, “How can parents choose from different healthy, safe feeding options if only one option is promoted?” Parents may find it difficult to access formula feeding information or find that instructional texts provide inadequate

development of formula feeding sections in favor of larger sections devoted to breastfeeding. Kahn (16 February 2012) argues:

By promoting exclusive breastfeeding, health officials run the risk of alienating an entire population of new moms who also need their help. They need to be educated on how to prepare and store formula properly, and how to supplement while optimizing breastfeeding (para. 4).

It is not that instructional texts completely ignore formula feeding instruction. *Parenting* magazine published 28 articles from 1996 to 2012 with references to baby formula. Each of the book-length instructional texts on baby care and nutrition referenced in Chapters II and III have significant sections explaining how to prepare and store formula. Instead, the problem resides with quantity of information disproportionately focused on breastfeeding instruction and the targeted argumentation that asserts breastfeeding's superiority to formula feeding. While synthetic acceptance messages attempt to strike a balance between these two feeding options by presenting merits of both breast milk and formula, the master narrative does not. For example, *The Baby Book* by Sears et al. (2013) allocates 48 pages to the breastfeeding chapter and only 16 pages to the bottle feeding chapter, which includes information about bottle safety that could apply to either pumped breast milk or formula. Ultimately, synthetic acceptance advocates recognize disproportionate instruction as "attack on women's access to information to make a legitimate choice" (Kahn, 2007, para. 1). By limiting access to an already limited number of formula feeding materials and delegitimizing formula as an acceptable first choice of parents, synthetic acceptance, as a pediatric nutrition narrative,

is often a secondary narrative choice of parents who fail to meet the breastfeeding benchmarks of moderate naturalism. . As Kahn (1 December 2011) surmises, “I’d hardly call it education if you only promote one thing as being right” (para. 4). For this to change, access to information must change and a proportionate balance of feeding information must be presented.

Second, synthetic acceptance advocacy has argued for feeding to become a women’s rights issue rather than a breastfeeding rights issue, that privileges one set of mothers and alienates another. “It’s time for mothers to put aside their differences and unite” (Behan, 2013, p. 4, para. 5). Kahn (25 November 2010) rallies women, breastfeeding and formula feeding, to “pressure” legislators who need them “to get elected” by uniting “to push for policy changes” (para. 5). The aim of such “pressure” would be to address broader issues that affect all women and that would better enable women to choose and implement feeding choices best for them. Rather than focusing attention on banning formula swag bags in hospitals (diaper bags with formula feeding instruction, coupons, and samples, which have been banned in states and cities such as New York City), synthetic acceptance argues that the focus should shift to extending and guaranteeing paid maternity leave, which would benefit breastfeeding and formula feeding mothers (Kahn, 8 December 2011; 25 November 2010). Ultimately, synthetic acceptance advocacy supports both breastfeeding and formula feeding education and promotion, but does so demonstrating concern for the implications of the advocacy. “We can increase breastfeeding rates if we approach it the right way. That does not include

bullying people or making them feel guilty for the choice they've made" (Kahn, 16 February 2012, paras. 7-8).

Third, synthetic acceptance advocacy promotes evaluation of pro-breastfeeding research. Popular reasons used to advocate breastfeeding, like the long-term reduction in childhood obesity and fostering maternal-child bonding, are up for speculation by advocates with the Moms Feeding Freedom Blog. Kahn (5 January 2012) writes,

We rely on scientific data for so much of what we do and how we conduct our lives. It's important, then, to keep in mind what the data shows [Infant Feeding Practices Study II by the FDA]. In the case of obesity, it shows no difference between breastfeeding and formula feeding (para. 5).

Furthermore, studies claiming benefits of breastfeeding contradict one another's findings. Kahn (6 October 2011) uses eczema prevention as an illustration. "A new study out of Britain gather data on more than 50,000 children and found that, contrary to popular belief, breastfeeding does not protect infants against developing eczema" (para. 1). In another challenge to research claims regarding the benefits of breastfeeding, Kahn (12 January 2012) questions a small sample size and the conclusions of a study that measured nine breastfeeding mothers' and eight formula feeding mothers' brain activity in response to their baby and an unknown baby crying. Responding to this type of exploratory rather than definitive research, Kahn argues,

First, the sample was T-I-N-Y. Second, there are a million reasons why mothers bond or don't bond with their babies. Third, try telling a mother who formula fed

that she's not bonded with her baby. I'd venture to say, animal instinct will surface and her claws will come out (para. 2).

The body of infant feeding research is large, and synthetic acceptance advocates do not question a number of claims related to the physiological benefits for the child. However, a number of claims are based on poor research including claims related to obesity, eczema, bonding, diabetes, SIDS, cognitive development and more⁸ (see also Kahn, 8 September 11 and 14 July 2011). The problem resides in research overstating breastfeeding benefits and understating formula feeding safety and nutrition. Synthetic acceptance advocacy may not be as vocal or widespread as moderate naturalist messages, but this vein of advocacy offers rationales and support for a pediatric nutritional narrative from birth through 12 months that legitimizes formula feeding and the various reasons that mothers may have for using this feeding practice. For advocates to become more prominent characters in the synthetic acceptance narrative, more prominent separate textual spaces are need, which will help articulate the narrative as an antagonism to moderate naturalism and enhance its legitimacy.

Synthetic Acceptance: Classed Narrative

A critical read of this narrative draws attention to class. To control the safety of nutritional sustenance within synthetic acceptance, mothers must have adequate resources. Formula feeding requires a certain amount of formula per day to meet a child's needs based on his/her age. Pediatric instructional texts do not address the financial needs of formula-feeding families from lower SES (except in their description

⁸ Academic research questioning the validity of scientific research asserting the benefits of breastfeeding are consistent with the Moms Feeding Freedom blog posts (see Wolf, 2007, 2011).

of breastfeeding benefits including lower cost). These texts assume that mothers will be able to budget for formula feeding and have choice regarding infant formula. This assumption is not applicable to lower income families. In terms of budgeting, even store-brand formulas may cost them between \$60 and \$100 per month (Babycenter.com, 2013b). In terms of choice, cost may dictate choice, and enrollment in social services like Women, Infants, and Children (WIC) will dictate choice⁹. Furthermore, lower SES mothers are more likely to engage in risky formula stretching due to limited financial resources (Kahn, 26 January 2012) and are penalized through social services like WIC for full formula feeding. Not only do these mothers bare the stigma that comes with their dependence on social services (Hays, 2004), they are also stigmatized by formula feeding. This stigma carries with it both social and material consequences.

Unfortunately, the primary organization allocated for governmental aid to these mothers and their children have adopted policies that privilege breastfeeding and penalize formula feeding. While families who qualify may be enrolled in the food package system through WIC, this system privileges breastfeeding by awarding them the greatest quantity and variety of foods as incentives and provides limited support for formula feeding mothers, subsequently adding layers of illegitimacy to formula feeding for women enrolled in social services (Food and Nutrition Services: Women, Infant, and Children, 2009, p. 4). By the organization charged with reducing their nutritional risks,

⁹ Each state negotiates with formula companies to get rebates for the lowest cost formula. Therefore, when a mother, who partially breastfeeds or fully formula feeds her baby, is enrolled in a food package system, she will not be able to choose the formula. The formula will come in one brand based on the state's agreement with the formula company. Exceptions to this include when a baby needs a specialty formula due to a physician's prescription (United States Department of Agriculture's Food and Nutrition Services, 2009).

formula feeding mothers are subject to social disapproval for failure to adhere to moderate naturalism and subject to material punishment through limiting their access to formula brands and types, and their access to the same quantity and variety of foods as exclusive breastfeeding mothers. With 9 million women and children enrolled in WIC's services per month and countless others who struggle to financially provide formula for their children, class remains a contextual concern under-addressed in pediatric nutrition instructional texts and evidences how feeding ideologies have become institutionalized (United States Department of Agriculture's Food and Nutrition services, 2012). There are many who stand to benefit from the articulation of synthetic acceptance as a counter pediatric nutrition narrative – mothers overwhelmed by pressures to breastfeed and feelings of guilt, mothers who need formula feeding information, and mothers who need formula feeding legitimized to help reform discriminatory social service practices.

Strict Naturalism

Imagine for a moment the home of a strict naturalist mother. While mom may not look like June Cleaver with every hair in place and 2 inch heels, her commitment to domesticity is evident in the homemade house cleaners, craft projects spread around, garden with organically grown vegetables, and Beaba Babycook baby food maker sitting out on the kitchen counter. Check out her organically-stocked pantry. Not only is this mom a do-it-yourself diva, she is ecologically minded. You won't find disposable pampers in her diaper bag. Oh no, organic cloth diapering or biodegradable diapers are her child's seat covers, or she might have already set out on the old-but-new craze of going diaperless. Her commitment to pediatric nutrition is just as much about her

natural lifestyle, political activism, and concern for Planet Earth as it is for the safety and health of children. This hypothetical household is a stereotype of what many have labeled natural or crunchy parenting¹⁰, and while natural parents self-ascribe “flexibility” in their nutritional repertoire (Newman, 24 April 2012), a narrative emerges from these instructional texts that prizes feeding practices and products that are defined by what they are not - chemically altered.

The counter narrative labeled strict naturalism is constructed from pediatric nutrition instructional texts in the secondary textual materials identified in Chapter II. To be clear, narrative fragments and traces of strict naturalism are evident in *Parenting* articles and baby care books, but instructional texts that focus on the characterizations, motivations, practices, and choices of strict naturalism are not the mainstream baby care messages. The attention to strict naturalist texts appears to be increasing in popularity (e.g. number of homemade baby food blogs, natural parenting blogs, and homemade baby food books), but parents are unlikely to find these texts and the messages that they contain in the average *Parenting* magazine. Parenting.com features a blog entitled

¹⁰ According to the Natural Parents Network, natural parenting is a philosophical approach to parenting, in general, that emphasizes attachment parenting practices, ecological responsibility, appreciation for the natural world, holistic health practices, and natural forms of learning (Naturalparentsnetwork.com, 2013). Pediatric and family nutrition are one component of natural parenting. Other components of natural parenting may, but do not necessarily have to, include baby wearing, co-sleeping, cloth diapering, purchasing clothing made of natural fibers, and spending family time outdoors. Therefore, natural parenting should not be equated with the nutrition narrative entitled strict naturalism described in this section. Instead, the relationship between the two is evidenced in the shared concerns over natural sources of nutrition, environmentally sound feeding practices, and appreciation for the natural world. With that said, parents adhering to strict naturalist pediatric nutrition narrative may not choose to participate in or adopt natural parenting as an ideology. Choosing to breastfeed exclusively and make homemade, organic baby food does not automatically mean that the parent will also adopt baby wearing (e.g. carrying child in a sling rather than placing child in a stroller), change clothing retailers, and enjoy outdoor activities with the family. However, it is likely that a parent who already practices some natural parenting components would find the strict naturalist pediatric nutrition narrative to have fidelity as it should be consistent with their overall approach to parenting.

“100% Natural Parenting” and links to like-minded blogs (e.g. Just West of Crunchy, Alt-Mama, Eco Child’s Play, and Mama Knows Breast) that self-identify as strict naturalists. Also product websites like www.honest.com maintain blogs about the aims, practices, and information essential for strict naturalism. Coupled with baby food books like *The Baby Food Bible* (Behan, 2008) and *The Best Homemade Baby Food on the Planet* (Knight & Ruggiero, 2010), these texts present a nutritional narrative in which parents are highly informed consumers, enacting their role as parent with similar goals and practices as their role as ecological citizen. Furthermore, the strict naturalist focus on parenting that centers on the mother during the first 4-6 months of breastfeeding extends its focus on the mother during the 4-6 to 12 month period, in which she prepares and stores homemade, organic solids.

Characterization of the Strict Naturalist Motivation to Go All Natural

Strict naturalism is similar to moderate naturalism in terms of feeding practices, especially in the first 4-6 months but differs in terms of its attribution of parental motivations for decision-making. The motivations noted in this section set strict naturalism apart as a counter narrative revealing its distinction from moderate naturalism. One way to determine the impetus for strict naturalism is to ask, “How do instructional texts rationalize adherence to naturalistic feeding practices or explain parents’ entry point into strict naturalistic practices?” The literature provides rationale for these practices: 1) frugality, 2) domesticity as a leisurely pursuit, 3) search for alternative nutritional choices, and 4) the “going green” lifestyle. First, the feeding routines, and other baby care practices, associated with strict naturalism may be pursued

with the goal of saving money and reducing waste. Both breastfeeding and making homemade baby foods are described as both inexpensive and convenient. Natural Parenting blogger, Taylor Newman (20 December 2012), writes, “I’m guessing most parents who make baby food once or twice and realize how easy (and cheap?) it is will consider it a no-brainer from there on in” (para. 3). Similarly, Knight and Ruggiero (2010) introduce parents to homemade baby food with this argument,

In an era where everything is fast – from the food that we eat to the pace that we keep – you might think it’s impossible to make your baby’s own food, but this book will show you how in surprising simple ways that save you time, effort, and money (p. 8).

Homemade baby food, a hallmark of strict naturalism, is often explained in terms of what it is not – expensive and time-consuming. As an “easy,” “fresh” and “inexpensive” alternative to commercial baby foods, homemade baby food instruction makes it sound as if baby food can be made in four easy steps – shop, cook, puree, and feed Gardner, 2012, p. viii).

Start with fresh fruit or frozen veggies (buy organic when possible), and steam until soft and tender, about 3-5 minutes for fruits like apples, plums, and pears, and up to 10 minutes for carrots, green beans, and other veggies. Whip up in the food processor or blender until smooth (Huber, 2012, p. 72).

Being frugal with time and money is prominently featured as a motivational appeal for strict naturalism. The emphasis on frugality to persuade mothers to try strict naturalist practices such as homemade baby foods is paradoxical in that the narrative is aimed at

and accessible to mothers with the financial means, leisure, and education. In other words, the appeal of saving money is used to recruit mothers who can invest the time, energy, and financial resources into making the homemade baby food.

Second, feeding practices, especially making homemade baby foods, are often portrayed as hobbies for strict naturalists. Newman (23 January 2012) blogs, “I just get a real kick out of DIY domesticity” (para. 6). In a baby food cookbook, Tamika Gardner (2012) describes making baby food as part of parents’ leisurely interest in cooking and as possibilities for socializing.

You might want to tune in to the Food Network or gather your prep cooks for this step! Time flies when you’re having fun, so preparing foods while watching Paula Deen or in harmony with your closest friends is a great way to add excitement to cooking (p. 31).

Whether or not parents sought out making homemade baby food as a domestic hobby or not, instructional texts seem to emphasize the opportunity the activity presents for satisfying leisurely interests.

Third, more than a frugal and domestic lifestyle, this nutritional narrative may also be spurred by the failure of moderate naturalism or other nutritional narratives to deliver the positive health outcomes to which they are associated. When the medical experts associated with the master narrative fail to account for health complications like severe allergies within their nutrition instruction, parents seek alternative narrative constructions for nutrition in order to improve the health of their children. Natural

Parenting blogger, Taylor Newman (23 January 2012), shares her story with her son's food allergies that led them to hemp milk and Chinese herb decoctions.

Finally, the aims of strict naturalism are aligned with an overall lifestyle associated with green living. Strict naturalist parents are motivated to feed their children based on their identification overall with a natural, eco-friendly lifestyle. Breastfeeding and making homemade, organic baby food are extensions of other familial choices. As Gardner (2012) writes in her book about organic purees, "Shopping for organic food can be a great outing for everyone to enjoy. Don't forget to take your reusable shopping bags to bring home all the wonderful food you purchase" (p. 31). The strict naturalist parent is already purchasing organic food for the family and shopping with reusable bags to conserve resources and reduce waste. In the first-ever 100% Natural Parenting blog post for parenting.com, the overall goals of strict naturalism are identified:

I think a lot of us are leaning more and more toward 'natural' parenting because, well, it feels right to us ("natural," if you will). I've cared deeply about my son's well-being from the get-go, but it's only since his birth that I've *really* cared about the planet – socially, environmentally – he, and the rest of his generation, will inherit" (Newmann, 23 January 2012, emphasis in original, para. 6).

Whereas risk aversion and healthy consumption are more narrowly focused on the child in moderate naturalism, risk aversion and healthy consumption is broadened in strict naturalism to subsume the family and society, more generally. Even brands such as Happy Family (2012) that makes organic baby food, produces products for older kids and adults as an appeal to the family's nutritional patterns, not just baby's. Further

evidencing this broader mindset, Newman (21 September 2012) writes that, “keeping our food and water supplies safe for our children is ultimately a collective choice” (para. 10). She advocates for mothers to “pressure the people who represent us in setting standards and making policies to make wise, sustainable decisions for our families, and our future” (emphasis in original, para. 10).

The strict naturalism’s discourse intersects with and complements other public discourses about health, nutrition, and the environment. Narrative scholars describe this as intertextuality (Sharf, et al., 2011). As these discourses intersect with one another in the lived and shared experiences of parents, parental choices about pediatric nutrition become stimulus for and a result of other natural-oriented choices. Furthermore, the messages associated with strict naturalism are more likely to achieve fidelity, that is “ring true” (Fisher, 1984), to parents, who already identify with a naturalistic lifestyle. The frugality, domesticity, medical necessity, and lifestyle impetus to adopt strict naturalism frames the following breakdown of the narrative chronology: pregnancy, birth through 4-6 months, and 4-6 through 12 months.

Pregnancy: Nutritional Preparation

“Raising a natural baby in a chemical world is not so easy” (Belli, 2007, p. 27). Pregnancy is an opportune time for parents to equip themselves with the knowledge and supplies necessary to implement naturalistic feeding practices given that it “is not so easy.” Honest Baby explains,

Research feeding options. Breastfeeding gives your baby a great start, but for many health personal reasons nursing exclusively isn’t always an option. If

you're concerned about what formula you may feed your new baby, call the hospital ahead of time to see what they offer and then do your research to find one that your family is comfortable with – we recommend organic (Eugene, 6 March 2013, para 4).

The focus on educational preparation is in concert with narrative of moderate naturalism as is the aim of this education – deciding to breastfeed. For more information about nutritional preparation to breastfeed, reference Chapter III. However, given the emphasis on the 4-6 month to 12-month stage, educational preparation for the strict naturalist parent is also focuses on learning about the safety and nutritional value of solid foods. The remainder of this section overviews solid food education.

Yes, parents are expected to attend to breastfeeding instruction in preparation to feed their children, but the strict naturalist emphasis on the introduction of solid foods also dictates attention to the quality and safety of produce, meats, and grains. Food education may impact family nutritional practices in terms of 1) how the pregnant wife eats, which affects her fetus, 2) how the nursing mother eats, which affects her infant, 3) how parents feed their 4-6 to 12-month old, and 4) how families eat, more generally. Keeping this in mind, food education begins with understanding the difference between organic and non-organic foods. In *The Best Homemade Baby Food on the Planet*, Knight and Ruggiero (2010) clarify the difference for readers.

The most basic definition of organically grown food is that it is produced without the addition of synthetic chemicals – including fertilizers, pesticides, herbicides, and fungicides – and without the addition of hormones such as bovine growth

hormone and antibiotics. It has also not been genetically engineered. To carry the official “organic” label in the United States, food must be grown according to a set of uniform standards approved by the U.S. Department of Agriculture (USDA) (p. 13).

The USDA’s organic certification exempts small farms that often sell their foods at farmers’ markets and through other local venues. These farmers must still meet the criteria set forth by the USDA to claim their products are organic and can seek a Certified Naturally Grown (CNG) certification (Gardner, 2012). The definition of organic functions to help parents identify the foods that they purchase as either organic or non-organic. Furthermore, organic food instruction explains why and how foods get labeled and why it is important to look for the label when shopping.

Just as moderate naturalism warns parents about the risks of not initiating breastfeeding postpartum, strict naturalism warns parents about the risks of commercial foods and exposure of young digestive systems to unnatural products. Strict naturalist’s texts differ in terms of their degree of adherence to organic only diets, but these texts do not differ in terms of their warning to parents about the potential harms that synthetic chemicals can do to a baby’s body. There appears widespread agreement within these texts to avoid non-organic foods on the USDA and FDA’s Environmental Working Group list of the toxic twenty due to high traces of pesticide residue. The Toxic Twenty include peaches, apples, sweet bell peppers, celery, nectarines, blueberries (domestic), blueberries (imported), strawberries, cherries, kale/collard greens, potatoes, grapes, spinach, lettuce, carrots, green beans (domestic), pears, plums (imported), summer

squash, and cucumbers (imported) (Gardner, 2013; Knight & Ruggiero, 2010). Newman (12 September 2012) cites several studies that provide evidence their harms.

And a July 2007 study conducted by researchers at the Public Health Institute, the California Department of Health Services, and the UC Berkeley School of Public Health “found a six-fold increase in risk factor for autism spectrum disorders (ASD) for children of women who were exposed to organochlorine pesticides.” No doubt these studies are the tip of the iceberg, too and I’m not about to volunteer my kid as a human petri dish by way of our dinner table” (para. 5).

Strict naturalists texts provide a wide array of health information about food to guide parents toward organic food choices and understand the health consequences associated with non-compliance. Similarly to justifications of breastfeeding as the only legitimate choice for infant feeding in the first 4-6 months, justifications for purchasing organic foods draws upon expert knowledge and scientific inquiry. Where as moderate naturalism draws upon the advice from pediatric medical knowledge to shape what constitutes good parenting, strict naturalists draw upon the advice of environmental knowledge to shape good parenting practices. In sum, pregnancy is an important educational time in the plot sequence of both moderate and strict naturalism. One major difference between strict naturalism and both moderate naturalism and synthetic acceptance is the focus strict naturalism places on solid foods. It is this emphasis that generates the need to self-educate about a feeding stage at least six months away. The

following section on birth through 4-6 months overlaps with the plot of moderate naturalism with a few noted and important differences.

Birth through Four-Six Months: Milk Diet

Like moderate naturalists, strict naturalism defines acceptable feeding from birth through 4-6 months as breastfeeding (preferred) and/or organic formula (acceptable alternative). Because of the overlapping role expectations to breastfeed for both moderate and strict naturalists, and the aforementioned differences in motivations between the two narratives, this section will briefly describe discussions of breastfeeding within texts that focus on strict naturalism. With that said, understand that most of Chapter III's discussion of breastfeeding expectations are similar, if not identical, for strict naturalists.

Breastfeeding in Strict Naturalism. Strict naturalists' messages about pediatric nutrition birth through one year reproduce the moderate naturalist narrative by emphasizing the mutual benefits of breastfeeding to mother and child and depicting challenges to breastfeeding as obstacles to be overcome in the pursuit of risk-averse and health-optimizing feeding. With that said, strict naturalism differs with moderate naturalism in several important ways: 1) strict naturalism positions breastfeeding as the most environmentally advantageous feeding method; 2) strict naturalism emphasizes political, social, economic, and cultural challenges to breastfeeding; and 3) strict naturalism views breastfeeding as an opportunity for advocacy. First, for the strict naturalist, breastfeeding produces the least amount of waste and is the most natural

means of feeding a baby. The mother's body represents a natural, unhampered source of complete nutrition in the first 4-6 months of life. Ansel and Ferreira (2010) state:

Breast is still best. Breast milk is nature's perfect first food and the best nutritional start. In fact, health experts recommend breastfeeding your baby exclusively for his first six months, if possible, and then offering both breast milk and solids until at least age one (p. 8).

Nature's perfectly suited food for babies is breast milk, and thus, breastfeeding becomes the preferred method of feeding for the first 4-6 months of a baby's life.

Second, strict naturalism acknowledges the challenges to breastfeeding presented in Chapter III and Appendix D, but strict naturalism shift the emphasis to political, social, economic, and cultural issues/challenges surrounding breastfeeding. Appendix G entitled Strict Naturalism and Challenges to Breastfeeding provides a synopsis of challenge type and representative quotes from strict naturalism blogs. Obstacles include: 1) which expert is responsible for assisting breastfeeding mothers, 2) lack of medical research and language to discuss the most commonly cited reason for the cessation of breastfeeding – lactation failure or poor milk supply, 3) censoring and demonizing public breastfeeding and depictions of breastfeeding, 4) the sexualized breast, 5) hospital policies and practices that normalize formula feeding or undermine breastfeeding, 6) child care, 7) limited maternity leave, 8) pumping, 9) socio-economic status, and 10) general lack of cultural support. Interestingly, failed breastfeeding efforts are not attributed as often to maternal efforts. By focusing on socio-cultural, political, and economic influences on breastfeeding, the locus of control as to the success of

breastfeeding (exclusive breastfeeding in first 4-6 months and continued breastfeeding through 12 months) shifts from the mother to larger issues like parental leave policies, cultural perceptions of the breast, socioeconomic status of the parents, employer-employee pumping policies/arrangements, and healthcare organizational policies and practices. This shift is similar to the justification within synthetic acceptance for cessation of breastfeeding and call to advocacy for women's rights to breastfeed and formula feed. "Breastfeeding works, but it can be hard in a culture that does not support it" (Behan, 2008, p. 31). Within the strict naturalism narrative, the answer to lack of cultural support is to change the culture.

Third, strict naturalism casts breastfeeding mothers in the role of advocate. While synthetic acceptance expresses the need for mothers to transform into political agents, strict naturalism characterizes mothers as already enacting their role as political agents. Whereas synthetic acceptance calls forth for women's rights advocacy, strict naturalism calls for a variety of forms of advocacy, most notably environmental advocacy.. The pediatric nutrition responsibilities attributed to the mother in moderate naturalism is heightened in strict naturalism as the mother is responsible for the embodied act of breastfeeding, advocating for cultural changes that will enable more successful implementation of breastfeeding, and advocating for feeding choices that are natural and environmentally conscious. In a review of New York Time's contributor Alissa Quart's (14 July 2012) opinion piece on "The Milk Wars," Newman (18 July 2012) writes.

The majority of pro-breastfeeding peeps also want to get more moms advocating for themselves – and their children – so that breastfeeding to the benefit of moms and babies *is* realistic, even in the midst of work and social realities. The more women who push against breastfeeding-at-large when they mean to push against bad doctors and uncompromising zealots, the more difficult this kind of positive social change is to make. I agree that every mom faces her own challenges, and I stand by Quart’s position that we, as moms, shouldn’t judge one another, ever, over these matters. I also agree with her that “we should be organizing for paid parental leave, subsidized day care and public preschool” (paras. 6-7).

Inevitably, strict naturalism adds layers to the moral responsibilities of mothers by prescribing advocacy duties to mothers. In other words, mothering is a political act.

While advocate may or may not be a role that mothers intended to assume as they breastfeed, Newman will not “let [the public] off the hook” and calls for cultural changes to improve breastfeeding support in interpersonal networks, hospitals, workplaces, and society (4 May 2012, para. 3). Breastfeeding becomes a feminist and family issue for the mothers with strict naturalism, who perceives the public at odds with these aims.

Breastfeeding is the preferable feeding practice of strict naturalism; notwithstanding, strict naturalism instruction acknowledges that complications to narrative plot may result in formula supplementation or replacement of human milk.

Organic Formula Feeding in Strict Naturalism. The initial child feeding choice for is breastfeeding, but if breastfeeding efforts fail, then mothers must pursue alternative feeding methods that still provide organic sources of nutrition for their

children. When mother is unable to continue breastfeeding, parents may choose to engage in milk sharing – an informal relationship with another mother who either breastfeeds the child or provides pump milk for the child – or purchase human milk from a milk bank. These two options allow for the child to continue receiving breast milk. The cost, inconvenience, and safety concerns related to these options are likely reasons that strict naturalism instruction rarely mentions them as viable alternatives to breastfeeding. However, strict naturalism instruction does present organic formula as a more viable alternative.

I was a little over three months in at the time, I think, but I'd supplemented with organic formula for a while by then, too, and I was - frankly – relieved to let breastfeeding go. Also disappointed, but still... definitely relieved. I really believe in the power of breast milk – and was fortunate to have friends with steady supplies who shared their milk with my son, Kaspar, to keep some of the liquid gold in the mix when I stopped breastfeeding him, but, for me, organic formula was a pretty good substitute when I really needed it (Newman, 5 November 2012, para. 3).

Because breast milk is the standard of natural nutrition from birth through 4-6 months, formula is a sub-par alternative. Nevertheless, as in Taylor Newman's experience, there are certified organic formulas that do not contain additives or other synthetic ingredients that deviate further from the natural standard. While strict naturalism maintains similar feeding actions as moderate naturalism from birth through 4-6 months, this section has highlighted some of the noted differences related to the characterization of the

breastfeeding mother as advocate and the acceptable type of formula feeding – organic formula. The subsequent section examines the 4-6 through 12-month stage of child feeding within strict naturalism, which is the stage with the most notable divergences from moderate naturalism.

Four-Six Months through One Year: Introduction of Solid Foods and Juice

Like the transition to breastfeeding, or various degrees of combo feeding, the introduction of solid foods is a new time period in the nutrition narrative, thus, this change in plot causes a new set of expectations for parents. This section notes the ways in which strict naturalism reproduces and challenges nutrition expectations moderate naturalism, plot development, and scene. Similarly to moderate naturalism, parents are told that transitioning to solid foods is about cultivating nutritious eating patterns for their children and developing an adventurous, fun attitude toward food. In *The Baby & Toddler Cookbook*, Ansel and Ferreira (2010) explain, “By offering baby a wide variety of healthful, tasty foods, you can help her become a well-rounded eater” (p. 6). In addition to facilitating a positive, exploratory attitude toward foods, parents are reminded of their responsibility to control the options given to their children to ensure only healthy choices are presented. If parents make their own baby foods, they are able to control the texture of the food to ensure that it is the appropriate thickness for the child’s oral development, the quality of produce and ingredients, and the use of thickeners, sweeteners, sodium, preservatives, and additives that are unnecessary for children (Ansel & Ferreira, 2010; Behan, 2008; Knight & Ruggiero, 2010).

Despite the similarities between moderate and strict naturalism surrounding attitudes toward solids and controlling the nutritional value of food options, these two narratives diverge when it comes to their preferences toward organic foods. Mothers within strict naturalism either purchase organic baby foods from a retailer or prepare organic baby foods. While the purchase of commercially processed organic foods is acceptable, the preference expressed in instructional materials is to purchase or grow the food oneself in order to prepare homemade baby food to achieve the greatest degree of control over the product and process. In order to prepare baby food at home, parents need supplies that will enable them to cook, mash/mill/puree, store, and feed their children. The wide array of baby feeding products comprises a growing market within the baby care industry. The following two subsections explain the savvy consumerist and domestic behaviors requisite for mothers to prepare safe and healthy foods within the home.

Consumerism and Strict Naturalism: An Unlikely Pair. Research investigating consumer culture and parenthood has noted the emergence of baby products and marketing that convince parents that informed purchasing decisions ensure the safety and well-being of their children and their status as “good” parents.

Within this baby culture, ‘good’ parents are those who buy their babies the kinds of products they need that promise to ensure (middle-class notions of) safety and success in the world. Through this process, babies and their parents are taught how to be consumers, and consumption becomes a ‘natural’ part of parenting and infant development (Maudlin, Sandlin, & Thaller, 2012, p. 213).

In the birth through 4-6 month time period, pediatric nutrition instruction on strict naturalism focuses on breastfeeding, which requires fewer consumptive decisions (exceptions include purchasing a breast pump¹¹ and specialized nursing clothing). The onset of solid food feeding marks a dramatic change in feeding needs. All of a sudden, feeding requires an array of utensils, appliances, and food products. Consumerist baby culture seems an unlikely coupling for strict naturalism given the emphasis on frugality and an environmentally-conscious lifestyle; nevertheless, whether making homemade baby food or purchasing organic, parents are expected to be informed consumers and equip their kitchens with relevant feeding products. Commonly recommended feeding products include: food press, food mills, all-in-one baby food makers, steamers, blenders, meat thermometer, baby food storage and serving containers¹², weaning spoons, and general cooking utensils (Knight & Ruggiero, 2010). For the scene of home, all-in-one baby food makers are described as convenient appliances, but come with a hefty price tag (e.g. Beaba Babycook Baby Food Maker at \$119.95 and Cuisinart FRM-1000 Baby Food Maker and Bottle Warmer at \$119.33 from amazon.com). While a conventional steamer and blender/food processor (separate kitchen appliances in many homes) can be used with similar results, all-in-one baby food makers are marketed to parents as easy-to-use kitchen appliances designed specifically for convenient, safe baby food preparation.

¹¹ Breast pumps can be very expensive, but new health care legislation and tax laws qualify these purchases for tax refunds, and WIC offices provide mothers with complimentary breast pumps (Melanie at parenting.com, 10 February 2011).

¹² Specialized baby food storage and serving containers are often advertised as BPA free, convenient, and designed for baby-sized servings. However, ice cube trays can be used for freezer storage and a regular bowl can be used for serving.

When the scene changes yet remains geographically close to home (e.g. eating at a restaurant, running errands, visiting a friend, etc...), parents are able to transport pre-made meals in baby food storage containers. Conversely, when the scene changes and parents are geographically distant from their kitchens, homemade baby food preparation and consumption becomes complicated. The kitchen appliances and utensils that facilitate convenient, easy meal preparation are no longer available for their use. Traveling presents conflict to strict naturalism plot. The resultant choices afforded within strict naturalism are to either carry cumbersome all-in-one baby food makers, purchase travel-friendly baby food preparation tools such as small manual food presses and mills, or to purchase pre-packaged, commercial organic baby foods.

If parents do not make their own baby food, there are other organic, minimally processed options available. Parents may decide to purchase commercially available organic baby foods due to schedule and feeding management, scene-related difficulties, preparation safety, and/or preferences of caretaker. On the shelves of most local grocery stores, the three major baby food manufacturers – Gerber, Heinz, and Beach Nut – offer organic varieties of stage 1-4 baby foods. But, there are also organic varieties not produced by these companies both in stores and online. For example, Happy Family began in 2006 and has grown to be named the fourth largest baby food company in the US in 2011 (Prevention, 2012). Happy Family demonstrates the growing market share of organic baby foods and the consumer demand that parents have placed on baby food manufacturers for organic options. As consumers, parents must purchase products that will facilitate what is perceived as the safest and most nutritious meal for their children.

In other words, if mom learns what to buy and purchases it, then mom can maximize the health of the child and minimize risks to health. Strict naturalism may disguise itself with appeals to frugality (e.g. save money by making homemade organic baby food), but it is an elitist narrative in the sense that mothers must be well educated about nutrition, have the time to make homemade baby foods, and be financially able to purchase the products to make organic foods at home or pay extra for commercially produced organic foods.

Domesticity and Strict Naturalism: A More Likely Pair. The following section highlights the relationship of the lead characters – the parents, generally, and mom, more specifically – to the primary scene – the kitchen. Strict naturalism prescribes feeding practices (e.g. making homemade food) that result in a domestic-orientation of parenting. The maternal relationship to private scenes of home embody contradictory discourses of discipline and empowerment as she chooses to enact a traditional gender role in ways that are politicizing and personally fulfilling. Mothers are countering moderate naturalisms’ insistence that organic and homemade are not healthier, and while their political actions are informed choices that empower them, their political actions simultaneously reproduce gender roles that associate domesticity with mothers. Butternut squash and beets may not sound like a traditional baby food, especially if you have shopped in the baby section of the local grocer over the last 50 years, but homemade baby foods have almost limitless varieties. Baby food cookbooks and blogs display recipes for foods such as “Beat, Squash, and Quinoa” (Ansel & Ferreira, 2010, p. 64) and “Pretty Please Peruvian Bean Puree” (Knight & Ruggiero, p.

109) with full-color pictures of purees and satisfied babies. Ingredients include foods and spices that the traditional American family is unlikely to stock in their pantry, spice rack, or refrigerator like leek bulbs, lamb steak, lima beans, and cumin. However, the kitchen is fully stocked with a great variety of spices, grains, legumes, meats, and produce to generate a multitude of flavors for baby. Subsequently, practices associated with strict naturalism tie mother to the kitchen in order to prepare homemade, organic meals and snacks from start to finish.

To begin, instructional texts emphasize safety – kitchen, storage, and food safety. First, kitchen safety instruction explains how parents are to prepare the scene.

Your baby is more vulnerable to food poisoning and foodborne illness than an adult is because his immune system is not fully developed. Also, his tiny stomach contains less acid and stomach acid can prevent harmful microorganisms from multiplying and getting into the digestive tract causing illness (Behan, 2008, p. 28).

To avoid exposing baby to harmful germs and bacteria, baby food instruction recommends that parents wash hands and all utensils with soap and water, cleanse all produce thoroughly (even if peeling), separate work stations with meats and other foods to avoid cross-contamination, and continually clean up after oneself in the kitchen to maintain the sanitization of the scene (Ansel & Ferreira, 2010; Behan, 2008; Knight & Ruggiero, 2010). Additionally, food storage is an important safety concern within strict naturalism. Within the scene, the refrigerator is an important appliance for food storage safety, and mothers must monitor their refrigerators (40°F) and freezers (0°F) (Ansel

&Ferreira, 2010, p. 29). Foods stored in the freezer will last for months if sealed properly, which is why cookbooks recommend batch cooking and freezing. While food storage containers used commonly in a kitchen can also be used for baby food storage, special baby food storage materials can be purchased online or in stores with baby sections. These products and promotion thereof entangle consumer behavior with food safety. While specialized baby food storage products are not necessary, they are marketed to mothers as if they are indispensable for both convenience and safety.

A final safety concern is the food itself. Strict naturalism should follow the same guidelines as moderate naturalism. Whereas the FDA certifies the safety of commercial baby foods, homemade baby foods must be deemed safe by the chef, which is usually mom. Mothers within strict naturalism must be educated about types of foods and the safety of foods as they steam/sauté/roast, puree, and concoct creative food combinations. Certain foods should be avoided early on because of their vitamin and mineral composition such as fresh beets, turnips, carrots, collard greens, and spinach high in nitrates. A high nitrate diet can result in low red blood cell count in a baby 4-6 months old. By avoiding these foods as ingredients in the early stages of introducing solids, parents can prevent anemia from nitrates (Behan, 2008; Huber, 2012). Overall, parents are encouraged to purchase or grow organic foods in order to protect their children from pesticides, genetically modified foods, preservatives, and other additives deemed risky and follow guidelines for food preparation to ensure that the composition of the food is safe and nutritious. By adhering to the kitchen, storage, and food safety

recommendations outlined in instructional texts, mothers are able to fulfill their role as domestically-oriented, consumer-savvy nutritionists.

The emphasis on domestic activity within the home is consistent with post-feminist domesticity. Domesticity is bound up in gender expectations that associate femininity with unpaid labor within the home – a gender construction that is historically classed and raced because of its inaccessibility to ethnic minorities and lower SES (Gentile, 2011). In particular, domesticity within strict naturalism enacts femininity in two distinctive and paradoxical ways. First, strict naturalism ascribes value to domestic labor, more specifically infant care through breastfeeding and making homemade baby foods. Post-feminism reproduces traditional constructions of femininity and that includes the woman's role in the kitchen (Hollows, 2003). The crunchy mom's role centers on her kitchen activities: making batches of purees, pouring over baby food blogs and cookbooks, reading about organic foods and ingredients, and cleaning up the countless utensils and appliances used to create and store food. Yet, as critiques of post-femininity point out, this form of femininity is a choice and form of female empowerment (Hollow, 2003). As in the case of immigrant Mexican women in Sukovic, Sharf, Sharkey, and St. John's (2011) study, food preparation can reflect larger hegemonic structures that emphasize private roles of women in the home while simultaneously reflecting a form of female empowerment, cultural identity, and expression of control within their situated experience. Cooking can symbolize empowerment, and it can also symbolize leisure. With a resurgence in what was the post-World War II cookbook found in contemporary televised and blogged cooking

(Hollows, 2003; Salvio, 2012), cooking, albeit for a baby, has become a hobby associated with being a foodie. Making baby food is both a domestic activity within strict naturalism and a form of activism, which leads into the second way in which femininity and domesticity are bound up in this narrative – activism. Secondly, mothers within strict naturalism view their domesticity as inextricably linked to their roles as political agents. The political role of mothers within strict naturalism is paradoxical because post-feminist domesticity has been criticized for its apolitical positioning of women (Genz, 2006). The enactment of femininity does reinforce the focus on the home as the scene for feminine expression, agency, and entrepreneurship (Genz, 2006), but this counter narrative also positions women as political agents who question the sanctioning of nonorganic food sources, using their homes as a means of empowerment and resistance.

Strict Naturalism Summary

In sum, strict naturalism's plot focuses on nutritional decision-making that provides natural practices and products for baby. Narrative action is primarily motivated by an ecological ideology that guides other parenting and lifestyle choices. Notwithstanding, other motivational forces may include frugality, domestic hobbies, and/or failed expert advice. As parents pursue strict naturalism, acceptable feeding options are limited to breastfeeding (most preferable) or organic formula during the birth to 4-6 month time period followed by the introduction of organic foods, preferable homemade organic baby food and juices during the 4-6 through 12-month time period. The conflicts in plot, especially during the birth to 4-6 month time range, are not

necessarily described differently than the conflicts in moderate naturalism's plot; although, the conflicts in plot that are foregrounded in the texts are related to larger socio-cultural, economic, and political issues to which the mother is expected to advocate for change. In strict naturalism, choice exists, but choice is limited – as in the case of breastfeeding versus formula, only organic formula will do if breastfeeding fails. Additionally, choice exists with regard to solid foods, but only organic options can be selected. Despite the increased political and domestic responsibilities attributed to mothers, strict naturalism is a counter narrative with increasing fidelity.

A Counter Narrative with Increasing Fidelity

The fidelity of strict naturalism resides with its intertextuality with environmentally-conscious parents, cultural developments of foodies, and the totalizing role of motherhood. To begin, strict naturalism and the politically active mother as the lead character complement discourses supporting environmentally conscious lifestyles and organic sources of nutrition. Momentum is building behind strict naturalism due to this intertextuality. Growing in legitimacy, more and more products and information are available for parents to learn about natural or crunchy parenting practices. Many practices within strict naturalism, both nutritional and otherwise, are cited as trendy amongst celebrities and wealthy parents (e.g. natural birthing centers, midwives instead of doctors, homemade baby food instead of commercial, and exclusive and elongated breastfeeding) (Newman, 23 June 2012). It is not enough for mothers to simply adopt strict naturalism as their own. Mothers become political agents for this narrative in the

scenes that they interact with other mothers. In *201 Organic Baby Purees*, Tamika Gardner (2012) encourages parents to use social media to spread this narrative.

Now is the time to take out your digital camera or camcorder to capture these precious moments. Proudly display photos of the organic purees that you make to your friends on Facebook or Flickr, and let the world see how you're raising a healthy and organic baby and inspire others to do the same (p. 35)!

The mother within strict naturalism is attributed responsibility for feeding his or her child natural foods, but the mother is also attributed responsibility for advocating that others do so as well. Natural parenting blogger, Taylor Newman, takes this characterization to motherhood to heart.

Sometimes I think natural parenting stuff is even verging on truly mainstream. But then I overhear a mom at the playground – as I did the other day – saying she had no idea you can make your own baby food, and I want to take her home, introduce her to my blender (look? Sweet potatoes plus blender equals baby food?), and promptly get her hooked on the good green stuff... Green parenting, that is (20 December 2012, para. 2).

The scene may change from one's kitchen to playground. Regardless, the mother is to use as many channels as she can (e.g. her personal blog, her fact-to-face relationships) to propagate strict naturalism to others, thus, recruiting more and more political agents known as mothers. Because strict naturalism complements environmentally-friendly living and is easily accessible to mothers with the financial and leisure means to fulfill its practices, this counter narrative rings true to many of those mothers reading one

another's food blogs, perusing one another's Facebook posts of pureed concoctions, and visiting about organics on the playground.

Next, strict naturalism's intertextuality with the totalizing role of motherhood explains its widening fidelity. As reviewed in Chapter I, feminist scholars have analyzed popular texts over the past 100 years, concluding that good mothering is associated with mothers who sacrificially give themselves over to their mothering role to maximize positive physical, psychological, and educational outcomes for their children while minimizing risks. Strict naturalism reverberates with the totalizing role of motherhood as mothers become nutrition experts, learn the risks related to non-organic products, and give themselves and their resources over to breastfeeding and preparing homemade baby foods.

While strict naturalism instruction is more readily available with more products available to facilitate organic consumptive practices, it remains a counter narrative. Strict naturalism is not what the majority of pediatric nutrition instructional texts advocate. In fact, *Parenting* along with other sources reported on a Stanford University study appearing in the *Annals of Internal Medicine* in 2012. This study concluded organic produce offered no nutritional superiority over conventional produce in terms of Vitamins A, C, and E. Taylor Newman (12 September 2012) points out that the study also demonstrates that conventionally-grown produce has dramatically higher traces of pesticides. Texts within strict naturalism are not passive regarding these claims. Unlike synthetic acceptance messages that fail to question the validity and conclusions of breastfeeding research, strict naturalism challenges research by experts. For mothers

like Taylor Newman, their roles as parents are more akin to political, social, and environmental activism, which helps to explain the increasing enthusiasm for strict naturalism. These mothers are not content to engage in individual action. Instead, they are taking their “cue” and their message “to guide our hospitals, workplaces, and communities...” (Newman, 6 June 2012, para. 6). Being a crunchy mother is another opportunity to shift the culture toward a healthier, more environmentally-friendly place to live for families now and for generations to come. Therefore, collective action is expected of these mothers. The strict naturalism pediatric nutrition narrative resists the acceptance of synthetic baby foods, whether formula or solids, and resists the apolitical characterization of motherhood in moderate naturalism.

Containing Strict Naturalism and the Political Mother

To contain the strict naturalism imperative to “go organic,” moderate naturalism texts untangle nutrition and activism. Lines like, “Buying organics for your baby is more of an environmental choice than a health one,” appear in *Parenting* and distinguish between making choices for the health of a child versus making choices based on the political activity of the parent (Schoening, 2007, p. 153). This containment strategy does not challenge the political activity of the mother within strict naturalism, but does challenge whether or not that political activity has health benefits for the child. When parenting instructional texts reproduce claims that conventionally-grown produce is as healthy as organically-grown produce and miss the concerns about pesticides and consequences related to ADHD, mothers in strict naturalism are reminded that they are not the status quo but, instead, are resisting it. The instructional messages representing

strict naturalism note the challenges and difficulties parents face in choosing to parent their children naturally and cast themselves as counter-cultural. For these mothers, nutrition and political agent are mutually constitutive.

Conclusion

Pediatric nutrition and child feeding practices give rise to discourses about parenting. Chapter IV has elucidated two counter narratives and their related parental discourses, which suggest differing maternal characterizations and motivations along with differing feeding practices. The following conclusion is divided into two sections to 1) highlight overarching characteristics observed across the three pediatric nutrition narratives and 2) put the three narratives in dialogue with one another to tease out implications.

Reviewing Four Overarching Characteristics of Master and Counter Narration

Overall, there are four characteristics evident in pediatric nutrition instruction that help understand these narratives in relation to one another and the master narrative. First, nutrition narratives have overlapping plot structures. Plot boundaries overlap with one another in that parents may perform similar feeding practices but perform them in different scenes, with different motives, and/or with different products. For example, mothers within moderate naturalism may feed their baby a variety of solid food types during the introduction of solid foods - homemade to commercial and organic to nonorganic. However, the plot strict naturalism limit acceptable solid food choices. For strict naturalism, children consume only organic foods, preferably homemade organic foods. The overlap in plots demonstrate adherence to expert advice about feeding

practices and deference to whom is considered an authority on pediatric nutrition instruction, but vary from one another in significant ways that represent different parental motivations and contextual and scenic constraints.

Second, narrative plots are permeable in that parents may shift to another narrative with some restrictions. To illustrate, parents who practice synthetic acceptance during the first 4-6 months of their children's lives may switch to moderate naturalism during the 4-6 month to 12 month time period by adopting the varied solid food practices associated with moderate naturalism, but they will not be able to switch from synthetic acceptance to moderate naturalism during the first 4-6 months unless employing a wet nurse or purchasing human milk from a milk bank. The restriction on plot permeability related to breastfeeding is due to human lactation processes. Once the mother foregoes breastfeeding or pumping breast milk for a time period, the maternal body reduces production of milk until the body ceases lactation altogether. While plots are permeable, there are constraints to permeability.

Third, parents may shift between narratives based on scenic and/or contextual features that enable or limit their abilities and motivations to fulfill a particular narrative's feeding practices. Shifting between plots is different than shifting to another plot. As described above, shifting to another plot is a relatively stable shift from one narrative with its set of expectations and features to a different narrative. Shifting between plots is an unstable, temporary shift that permits incremental changes in feeding practices. For example, in moderate naturalism mothers may occasionally make homemade organic baby food while at the scene of home (a practice associated with

strict naturalism) but use processed baby food when the scene changes to eating at a restaurant, visiting family and friends, sending the child to child care, and traveling. Changes in scene may make it more difficult to achieve the aims of strict naturalism and less difficult to achieve the aims of moderate naturalism.

A fourth characteristic of these narratives are the variances with regard to legitimacy. Due to the prevalence of the master narrative and its power in shaping what constitutes good parenting, counter narratives whose plots, characterizations, and actions overlap with the master narrative should logically ring true to parents. Conversely, counter narratives whose plots, characterizations, and actions that diverge from those of the master narrative should, logically, lack fidelity with parental audiences and have less legitimacy as viable pediatric nutritional narratives. In comparison to the legitimacy afforded the master narrative, strict naturalism is positioned to overlap with moderate naturalism's characterization of maternal self-sacrifice more so than synthetic acceptance in regard to breastfeeding. Conversely, synthetic acceptance is positioned to overlap with moderate naturalism more so than strict naturalism in regard to introducing solid foods. Higher degrees of overlap may afford greater levels of legitimacy to strict naturalism in the first 4-6 months and synthetic acceptance between 4-6 and 12 months because their instruction may have greater degrees of fidelity with parents who are exposed to large quantities of moderate naturalism instruction.

Reviewing Synthetic Acceptance and Strict Naturalism in Dialogue with Moderate Naturalism

The interdependent relationship between pediatric nutrition and parenting is evident in statements like, “And remember that feeding isn’t just about giving nutrition. It’s a perfect opportunity to interact and connect with your baby” (Sears, 2001). Chapter IV has teased out two pediatric nutrition narratives that voice alternative characterizations of parental motivations and narrative action and plot with regard to feeding practices. On one hand, the plot of strict naturalism emphasizes the chronological period from 4-6 through 12 months, in which organic, homemade baby food becomes the means to achieve an ecologically-friendly lifestyle for the family. On the other hand, the plot of synthetic acceptance emphasizes the chronological periods of pregnancy to birth and birth to 4-6 months, in which formula feeding becomes a means to gain control over pediatric nutrition.

Despite the divergence between these alternative narrative constructions, they converge at various points. These two counter narratives reverberate with political tones unvoiced in the master narrative. Strict naturalism and synthetic acceptance may be at opposite poles in regard to their motivation to feed their children organics, but these two narratives both promote broader cultural and political changes that would enable mothers to enact their baby feeding decisions (e.g. enforcement of breast pumping space at work, extended maternity leave, etc...). Strict naturalism positions mothers as political agents that resist medical experts separation of nutrition and environmental activism. Instead, mothers within strict naturalism become well-educated about

nutrition, the risks of synthetics and genetic modifications within foods, and the positive health outcomes associated with organics. Rather than enacting their resistance silently, strict naturalism expects that mothers voice their organic lifestyle to others with the aim of increasing awareness and participation. Subsequently, strict naturalism, as a political counter narrative, functions to not only shape pediatric nutrition instruction but to recruit characters, that is other mothers, to join in the domestic-centric plot. Synthetic acceptance advocates also promote mother as political agent but do not use the same naturalistic framework as strict naturalism. As political agents, mothers voice women's rights –right to breastfeed and formula feed – by drawing attention to social and structural forces that oppress women. By emphasizing equal access to formula and breastfeeding instruction and equal support for formula and breastfeeding mothers, synthetic acceptance, unlike strict naturalism, legitimizes a plurality of feeding practices and aims to shift the focus from particular feeding practices within the narrative to women's rights more generally. However, the plurality accepted within this narrative is undermined by discourses of guilt associated with formula feeding, which ultimately reproduce “breast is best” discourse.

In addition to their political overtones, strict naturalism and synthetic acceptance converge in their attempts to normalize formula feeding even if one is pickier about the formula type. Synthetic acceptance attempts to increase formula feeding legitimacy by demonstrating the control it can render over complicated plots. Formula becomes a means to restore control to mothers with breastfeeding problems, to difficulties in managing scenic changes like the return to work, and to distribute childcare

responsibilities. Strict naturalism also attempts to increase formula feeding legitimacy by accepting the use of organic formula. Nevertheless, both narratives fall short in their resistance to exclusive breastfeeding. Synthetic acceptance falls short by failing to question the medical knowledge and experts that overstate breastfeeding benefits, failing to legitimize formula feeding as a first choice feeding option, and by failing to problematize formula feeding guilt. Strict naturalism more actively promotes exclusively breastfeeding and falls short in legitimizing organic formula feeding by emphasizing extreme cases in which formula is needed (e.g. milk allergy).

Chapter III and IV have constructed the master and counter pediatric nutrition narratives. Included in these chapters is critical narrative analysis. However, there are implications spanning across the three narratives regarding authority. Pediatric nutrition instruction has power over what constitutes good parenting and is an important critical thread that needs further attention. Chapter V addresses the roles and implications of authoritative characters in the master and counter narratives.

CHAPTER V

CHARACTERIZATIONS AND IMPLICATIONS OF AUTHORITY

Thinking back on feeding three children during the birth to 12-month time period and narrative roles, plots, motivations, scenes, and contextual features that influenced my perceptions of good and bad parenting, I remain thankful for the instructional sources of information that helped me understand nutritional options and consequences associated with feeding practices. While, at times, I felt a sense of condemnation when my best efforts toward narrative adherence to moderate naturalism remained unrealized, the majority of the time I found instructional texts helpful. Admittedly, there were times when what I read seemed as if it were written in a foreign language. “I am supposed to do what?” Yet, most of the time, I was grateful that this information was a flip of the page or click of the mouse away. When I was desperate for my first son to latch on and could not seem to get breastfeeding to work, I was able to look up information on pumping milk and supplementing with formula until I could get an appointment with the lactation consultant. When I did not know what food to introduce first or how to prepare rice cereal, I searched parenting.com for answers. Reading these manuals, articles, and materials increased my efficacy as mother.

Overall, the instructional texts on pediatric nutrition are aimed at helping parents, like me, implement healthy feeding practices during their children’s first year of life. Parents stand to benefit from utilizing resources such as *Parenting* in many ways including: increased knowledge in regard to cause-effect relationships between child feeding practices and health outcomes, instruction on how to implement child feeding

practices, and advice about how to overcome obstacles to child feeding. Nevertheless, a critical reading of the pediatric nutrition master and counter narratives have revealed the limited and essentializing constructions of good parenting through their emphasis on the postfeminist, totalizing mother. Pediatric nutrition instruction takes on distinctive narrative logics inscribed with health, feeding, and parenting discourses that reproduce cultural norms that privilege some while marginalizing others. These expressed concerns do not invalidate the positive health messages disseminated through pediatric nutrition texts. Instead, these implications should elucidate the need for open-ended dialogue about how to continually shape and reshape parenting instruction in ways that promote egalitarian distribution of household labor, improved health of the family overall, and a plurality of legitimate pediatric nutrition narratives. The analysis of moderate naturalism, strict naturalism, and synthetic acceptance was explored in Chapters III and IV, but an important critical component to narrative analysis needs further attention – authority. Chapter V extends the critique of authority in the master and counter narratives to tease out how authority is established, which characters have authority within the narratives, how authority shifts and changes, and how authority silences characters, scenes, and contexts. Chapter V argues that authority is attributed to 1) characters within pediatric nutrition texts and 2) the instructional texts, which become authoritative characters.

Authority in Pediatric Nutrition Narratives: Whose Voice Matters

Authoritative characters have the power to influence the actions, motivations, and roles of other characters within the narrative. From a critical perspective, concern is

raised as to the messages that (re)produce structures of authority in the family and traditional gender roles. Two questions rise to importance in understanding power, family, and pediatric nutrition. First, whose voice is most powerful in shaping what is considered “good” parenting in the context of pediatric nutrition? Second, what are the implications of these power structures? This chapter draws attention to the ways in which medical experts and the instructional texts that cite them become powerful voices in narratives of pediatric nutrition and explores the implications. The chapter is laid out in the following organizational structure. To begin, discussions of each nutrition narrative clarify the unique and shared authorities within the narratives, and how those authorities shape the narrative components. Next, by exploring two interrelated frameworks, the Voice of Medicine and the medicalization of motherhood, the analysis contextualizes the role of medical knowledge and expertise in widely-noted theoretical explanations related to health and power. Furthermore, I address how these influential characters reinforce their authority, suppress alternative voices, isolate mothers, and generate dogmatic constructions of “good” parenting.

Characterizations of Expert within and across Pediatric Nutrition Narratives

While moderate naturalism, synthetic acceptance, and strict naturalism feature experts second only to mothers in their nutrition narratives, the experts and their prescriptions are characterized differently across the master and counter narratives. For a summary of how the three nutrition narratives use experts and what constitutes an expert in the narrative, see Appendix H entitled Characterizations of Experts across Nutritional Narratives. First, moderate naturalism delineates experts as the American

Academy of Pediatrics (AAP), biomedical research, pediatricians, nurses, lactation consultants, and the La Leche League. These groups of professionalized experts are the mouthpieces for science, and thus, they have indisputable authority regarding pediatric nutrition. In relationship to parents, these experts are whom mothers are recommended to seek feeding advice and assistance. As conflicts to breastfeeding plots arise, these characters, mostly through mediated communication, weigh in with their advice to overcome every obstacle. Moderate naturalism has a mutually constitutive relationship with medicine. In other words, moderate naturalism's power and widespread appeal is dependent on the credentialing of medical organizations, research, and practitioners, but likewise, the mass appeal of these experts and their instruction is the narrative structure it is packaged in through pediatric nutrition texts. As a narrative, science becomes culturally relevant or has fidelity with parental audiences.

Second, synthetic acceptance shares the same set of experts as moderate naturalism, with the exception of exchanging La Leche League for formula feeding mothers, but characterizes their expertise and role in the narrative slightly differently. While synthetic acceptance does not question science, this narrative does express three concerns regarding science and how experts utilize this science. First, synthetic acceptance advocacy calls for better research design and reporting so that breastfeeding benefits are not exaggerated. Next, synthetic acceptance uses maternal feeding stories to express concerns as to how science is used to promote feeding practices that may not be the best for a particular family, given a variety of physiological, psychological, social, cultural, and contextual factors. Finally, synthetic acceptance implies that science

promotes a dogma related to feeding practices resulting in judgment of mothers who do not adhere to expert advice. Despite these concerns, medical organizations and practitioners, that give science its voice, retain their authority. These authorities are whom mothers turn to for reassurance when they switch narratives and express guilt over an inability or difficulty breastfeeding.

Third, who is considered an authority shifts in strict naturalism, especially in the introduction of solid foods. Strict naturalism does not question science, but this narrative values a different type of scientific inquiry – environmental and food-based research that supports natural living. Value of situated experience and knowledge is another shift in strict naturalism. That is not to say that this form of knowledge is not present in moderate naturalism, but mom-to-mom breastfeeding advice functions as anecdotes to help experts relate to their audience; whereas in strict naturalism, mothers' experiences with food, especially making their own organic baby foods, are valued and shared amongst one another. These mothers express that their self-directed education about health, nutrition, and organics situate themselves to give better pediatric nutrition advice than pediatricians. Additionally, strict naturalism gives us a glimpse of the past, and opportunities for the present and the future, in which pediatric nutrition and the maternal role are constructed primarily through women's community with one another. Strict naturalism reminds us that pediatric nutrition authority is not commonsensically attributed to a professionalized medical class in society and that maternal, situated experience constitutes knowledge as well. All three narratives derive credibility from experts, but who is considered an expert and how those experts are characterized varies.

The attribution of authority to science and medical professionals can partially be understood through two widely noted frameworks, which will be overviewed in the following section.

Frameworks for Understanding the Power of the Medical Expert and Scientific Knowledge

In part and generally speaking, extant literature has shed light on issues of power in discussions of the Voice of Medicine and medicalization of motherhood. To begin, the Voice of Medicine has been, arguably, a powerful determiner of what constitutes knowledge in Westernized health contexts (Mishler, 1984, 1997). While initially applied to the understanding of medical interviews (Mishler, 1984), biomedical discourse, more generally, grants legitimacy to objective, scientifically verifiable information and the medical experts who have acquired formal, specialized education and credentialing. In terms of the medical interview, Brody (1994) provides insight to social power attributed to medical doctors. However, Brody (1994), like Mishler (1984, 1997), position medical doctors to use their power ethically to listen to patient's experiences and work with the patient to make sense of and plan for their health. That is to say, the very presence of the Voice of Medicine does not mean that it has to silence the voice of its counterpart – the Voice of the Lifeworld. The Voice of the Lifeworld grants legitimacy to subjective experience and offers a critique of the limits of the Voice of Medicine. While initial research on the Voice of Medicine and the Lifeworld focused on doctor-patient relationships, these concepts have broader implications. In terms of pediatric nutrition narratives, the Voice of Medicine, comprised of a wide array of

medical organizations and practitioners, become central characters of authority within the narrative due to their specialized education and medical research. These experts cite medical research and other credentialed experts to reinforce the validity of their scientific claims and their influence over what constitutes good parenting. Because culture affords these experts credibility and grants them voice, it is more likely that their instructional advice will resonate with parents when determining how to parent their children.

The Voice of Medicine is translated through popular parenting texts and centers on the natural world discovered through the scientific method. Pediatric nutrition texts rely on biomedical discourses to formulate instruction but word it in a way that is readable for their audiences. Maternal feeding stories are one way that the Voice of Medicine is translated to audiences, and it is also one of the ways that the Voice of the Lifeworld disrupts the social power afforded to experts. “Maternal feeding stories” is a term that I use to label the use of maternal experiences within instructional texts. Maternal feeding stories function differently in the three narratives, which will be explored later, but they have the potential to shift power imbalances and give voice to the Lifeworld. Maternal formula feeding stories within synthetic acceptance and strict naturalism give insight into how the Voice of the Lifeworld can disrupt the power relationship of medical experts and science and ascribe value to non-experts.

To illustrate how the Voice of Medicine and the Lifeworld have implications for pediatric nutrition instruction, I will review Foss’ critical content analysis of *Parenting* magazine’s breastfeeding discourse. Foss’s (2010) examination of breastfeeding and

formula feeding trends in *Parenting* concluded that medical or health experts were used to support infant feeding instruction regardless of what ideology was being promoted at a given point in history. Thus, the social power of medical experts was unquestioned in both pro-breastfeeding and pro-formula feeding messages. In relation to my study, which reflects a broader range of pediatric instruction (e.g. more instructional texts analyzed, inclusion of introduction of solids), I reach similar conclusions about the reliance on the Voice of Medicine. However, Foss (2010) concludes that pediatric instruction in *Parenting* magazine lacks representations of maternal experiences, or in my terms, maternal feeding stories that represent the Lifeworld. My analysis of pediatric nutrition instruction does not support this claim. The Voice of the Lifeworld (Mishler, 1984, 1997) is fundamental to the appeal of pediatric instruction, especially for web-based instruction. More than just anecdotes, maternal feeding stories and mother-to-mother advice in interactive communities are widely featured, which will be analyzed in greater detail in a later section. The problem is not that texts lack descriptions of maternal feeding stories; the problem is that the descriptions rarely contest biomedical discourse and become the Voice of Medicine in storied form.

Secondly, and more focused on the role of the mother, the medicalization of motherhood explains the shift in authority from the family, specifically the mother, to external professionals or experts such as pediatricians, lactation consultants, and health educators in the context of pediatric nutrition (Dubriwny, 2010; Marshall, Godfrey & Renfrew, 2007; Miller, 2005; Schmied & Lupton, 2001). The mother is not the authority on how to parent but retains responsibility for good parenting by acquiring the

knowledge and practices proposed by experts and implementing them in the care of her dependents (Wolf, 2011). In terms of pediatric nutrition, the mother, then, is primarily responsible for familial education about feeding choices and implementing these choices, but she does so by relying on the instruction of experts rather than following her common sense, experience, or non-expert counsel. In particular, this relationship between responsibility and education is evidenced in Chapters III and IV's descriptions of educational preparation during pregnancy. Moderate naturalism stresses the importance of prenatal education about breastfeeding relying on scientific evidence of the mutual benefits of breastfeeding, and strict naturalism instruction stresses the importance of education about both breastfeeding and organic food relying heavily on the scientific studies like the USDA and FDA's Environmental Working Group Study on pesticide residue in foods (Knight & Ruggiero, 2010). For a concise representation of the Voice of Medicine invoked in biomedical research and medical organizations/practitioners and the Voice of the Lifeworld invoked in different types of maternal feeding stories, see the Appendix H Characterizations of Expert Across Nutritional Narratives.

Considering the Voice of Medicine, the Voice of the Lifeworld, and the medicalization of motherhood in relation to pediatric nutrition narratives, *Parenting* magazine and other instructional texts do not just cite authoritative characters, they become them as well. Instructional texts become characters. Their power is derived from the fidelity between the type of experts represented within the texts and the type of narrative. For example, pediatric instructional texts that fall within moderate naturalism

use the AAP, pediatricians, other medical practitioners, and La Leche League to establish their credibility. Because these types of experts voice culturally powerful biomedical discourse, their voice rings true with what parents perceive as having expertise within pediatric nutrition. In turn, the texts themselves become synonymous with the experts cited within them. The texts are positioned to have authority within the family to provide parents with the knowledge and practices that they indicate are best. Another way to understand how texts become authoritative characters is to consider how texts may be referred to. Rather than saying, “The AAP recommends exclusive breastfeeding for the first 4-6 months followed by continued breastfeeding as solids are introduced,” parents may say, “*Parenting* says that we need to breastfeed...” Therefore, instructional texts become characters with the ability to either reproduce or contest the power of biomedical discourse as described in the aforementioned frameworks of the Voice of Medicine and the medicalization of motherhood.

Establishing Authority: Producing Tensions Between Medical and Lay Advice

From a narrative perspective, interest resides with which characters in pediatric nutrition narratives become influential in socially constructing what is perceived as “good” parenting. Science, and the medical knowledge and professionalization that it gives rise to, are arguably the backbone of pediatric nutrition. However, what has not been explained is how biomedical authority is accomplished given the array of characters implicated in pediatric nutrition narratives and the presence of maternal feeding stories, which often express the Voice of the Lifeworld rather than Medicine. Pediatric nutritional texts acknowledge that parents experience a myriad of, often

conflicting, advice from a diverse set of characters including doctors, nurses, lactation consultants, family, friends, coworkers, and even strangers in grocery store aisles and restaurants.

Tilsner (2012) writes, “The rules aren’t written in stone” and continues by explaining how the updated editions of *Dr. Spock’s Baby and Childcare* demonstrate such drastic changes in pediatric nutrition advice over a 30-year period. As indicated in Chapter III, the American Academy of Pediatrics even recently changed age guidelines for the introduction of certain solid foods. Given the historic variances in baby feeding recommendations, *Parenting* recommends that parents make decisions that are best for the family and the unique understandings of their children’s needs. In Wood’s (2003) *Parenting* article, she advocates that parents listen to others’ advice but make decisions best for them. “After all, you’re the one who lives with your baby—not your doctor, your mom, or your buddies—so there’s an awful lot you can figure out on your own, even though it may not feel that way at first” (p. 115). At face value, this advice appears to tolerate a diversity of practices and promote a balance between medical and lay advice. This advice seems to privilege the mother and attempt to restore high degrees of self-efficacy in her ability to make feeding decisions. With that said, instructional texts encourage parents to make educated, informed decisions, and, thus, parents must seek sources of information in order to make informed decisions. These informational sources, referred to as pediatric nutrition instruction and instructional texts in this study, shape what constitutes commonsense and instinctual.

While a commonsense “trust your instincts” understanding reverberates through texts, the overwhelming favoring of medical professionals and scientific research to introduce, support, and verify nutrition instruction generates credibility for advice from those with medical and scientific expertise and delegitimizes advice from other sources. Furthermore, *Parenting* uses medical professionals as the source of this “follow your instincts” advice. Paula Elbirt, M.D. and author of *Dr. Paula’s House Calls to Your Newborn* is quoted by Tilsner (2012) saying, “Fortunately your [mom’s] best judgment is probably right.” Why does *Parenting* need to quote a medical doctor and author of an infant care book to tell parents that they know what is best? The answer lies within whose advice has more credibility with parents – experts.

Authority of Scientific Research and Medical Experts within Instructional Texts. In order to position themselves as authorities, instruction juxtaposes scientific, evidence-based parenting advice with non-expert or nonprofessional advice. Even article titles like, “What You’ve Heard: ‘The Bigger My Baby, The Sooner I Should Feed Her Solid Foods,’” suggests that parents must sift through scores of messages aimed to help them parent, but as McCarthy (2005) and Eyla Bois, M.D., professor of pediatrics at the University of California San Diego School of Medicine, advise, parents must weigh the advice against scientific evidence. Fortunately for parents, instructional texts have coalesced the research, translated it to make it understandable, developed actionable messages, and provided an accessible way for parents to compare medical and layperson advice. For example, in an issue of *Parenting*, McCarthy (2003) frames

advice from non-experts (e.g. neighbors, family members, coworkers, and friends) as condemning and wrong, and advice from experts (e.g. pediatricians) as right.

And if you're like most new parents, you're probably getting advice from every corner. "As soon as you have a baby, everyone acts as though they were asked to serve on the committee on how to feed her," says Loraine Stern, M.D., coeditor of the American Academy of Pediatrics' (AAP) *Guide to Your Child's Nutrition*. "They'll tell you what you're doing wrong, so your job is to nod and smile and to keep doing what's working well for you and your baby." To get you started on the right track, we've asked the experts to answer common questions (McCarthy, 2003, p. 96).

This sentiment is echoed in other articles and in other instructional texts. The central message is that *Parenting*, other nutritional texts, and the medical experts are the authoritative characters for which to turn to for nutrition help.

Characterization of Non-Expert Advice. As instructional texts position themselves as characters with the expert knowledge to direct parents toward healthy nutritional choices for their children, the texts waver in terms of how they characterize other sources of advice. There are two different ways in which non-expert instruction is framed in juxtaposition to expert instruction: 1) intrusive and 2) risky. First, the voice of non-experts is framed as intrusive. From "nosy strangers" to overtly critical family members, non-experts are characterized as overstepping their boundaries and intrusively offering their self-appointed "expert" opinions (Moore, 2005, p. 100, 101). These depictions assume that non-experts' advice is unwarranted, judgmental, and impolite.

Such characterizations position mothers in opposition with other characters within the narrative and prime mothers to perceive non-experts as intrusive. This type of adversarial positioning may inhibit mothers from seeking out nutritional advice and social support from these characters, who may not be as meddlesome as they are made out to be in the narratives. Second, the voice of non-experts is framed at the very least as unhelpful and at the extreme as risky. Pediatric nutrition instruction identifies common forms of non-expert advice as myths that circulate in social networks. One such myth is that adding rice cereal to a bottle (formula or breast milk) will cause babies to sleep through the night. McCarthy (2013) dispels this myth by citing research conducted at Cleveland Clinic and quoting a spokes-person for the American Dietetic Association. While advice ranges (e.g. nursing in public, when to start rice cereal, when to feed table foods), mothers are usually reminded to “ignore” unhealthy advice (Rowley, 2013, p. 2, para. 7 & 9). Although non-experts may be characterized as annoying by interjecting sub-par advice, not all non-expert advice is depicted as such.

Evaluating and Co-opting Non-Expert Advice. At times, instructional texts affirm the supportive roles of advising partners, family members, and peers, but at other times, instructional texts are critical of such advice and its power to shape constructions of good and bad parenting. Instructional texts establish an evaluative framework, a litmus test of sorts, to determine the validity of non-expert advice. The degree to which it reinforces the master narrative’s use of biomedical discourse determines the degree of validity of the advice. When non-expert advice fails the litmus test, *Parenting* recommends deflecting such advice by repeating expert recommendations. “Be gentle

but firm. Blaming your pediatrician ('Our doctor says to wait to start solid foods') might help take the heat off' (Moore, 2005, p. 103). Instructional texts affirm non-expert advice when such advice reinforces the overall messages and feeding actions of the master narrative. *What to Expect the First Year* states, "If the advice that's been offered seems as if it may actually have some validity, but you're not sure, check it out with your baby's doctor or with another reliable source" (Murkoff & Mazel, 2010, p. 326). The medical profession, and the scientific evidence for which its recommendations and practices are based, are positioned externally (e.g. clinical scene) and internally (e.g. quoted in instructional text) to provide the final verdict on what constitutes good parenting. Therefore, the voices of non-expert characters must pass the litmus test of experts to determine whether or not it fits within expert instruction. More than providing evaluative frameworks for judging the merits of non-expert advice, pediatric nutrition texts also co-opt non-experts when it suits their needs.

In terms of maternal feeding stories in *Parenting*, contributing authors often solicit maternal experiences to include their stories in the publication. These maternal feeding stories present instruction in distinctly narrative formats from their situated experiences, which is characteristic of the Voice of the Lifeworld, but these stories are often flanked by medical experts weighing in on the subject, explaining the results of medical research, or touting feeding practices closely associated with the risk-averse and health-promoting agenda set forth by their profession. Consider this maternal feeding story:

Breastfeeding proved to be equally challenging for me. I went into it thinking I had to follow all the rules from the get-go—don't introduce an artificial nipple too soon, don't pump right away—and ended up exhausted and ready to call it quits. That is, until I talked to a friend who said her husband had given both her daughters nighttime bottles with no ill effects. I decided to give it a shot, and Anthony went back and forth effortlessly between bottle and breast. Plus, I got an extra two months of frozen breast milk (Wood, 2003, p. 115).

This story is sandwiched among down-to-earth, commonsense advice, other maternal feeding stories, and quotes from experts like associate professor of pediatrics at UCLA, Dr. Karp. The central message of this maternal feeding story affirms that non-expert advice may be helpful. Specifically, her friend's advice is followed and proves successful. It is important to note what constitutes a successful outcome in the maternal feeding story – exclusive breastfeeding. The friend's advice follows moderate naturalism and its underlying discourse that “breast is best.” Because the outcome of pumping and permitting the father to bottle-feed led to an increase in milk supply, this story reinforces exclusive breastfeeding. Despite its storied form and peer-to-peer relational context, the integration of this maternal feeding story into *Parenting* functions to generate popular appeal for biomedical discourse. In a sense, this type of non-expert advice does express the situated experience of mothers but is selective in terms of which experiences to voice.

Interactive media presents another opportunity for mothers to post their maternal feeding stories as comments to online articles, as blog posts, and as prompts and

responses within a discussion board/online community. The Baby Center website, like most other parenting resource sites, features stage-based instruction on pediatric nutrition written by nutritional and medical experts, but it also includes sections for featured blogs, community groups and discussions with other mothers, and “mom answers.” With these types of open forums for mothers to communicate with other mothers, sharing stories and advice with one another, there is a semblance of distributed authority to both medical experts and everyday parents. Upon reading the blogs, community posts, and mothers’ answers related to pediatric nutrition, I found that maternal messages often take the form of personal narratives yet reproduce expert advice. To illustrate, consider this example response to a mother who opened up in Baby Center’s online community and asked other mothers for advice on weaning her infant so that she could focus on losing weight.

KEEP BREASTFEEDING!!! 1. It is amazingly great for baby, nutritionally and emotionally for both of you. 2. You burn something like 500 calories when you are exclusively breastfeeding! I gained a ton of weight when I got pregnant with my 1st (giving into all my pregnancy cravings wasn't exactly a great idea) :) I have lost 70 of the 90 pounds I gained, baby is now 13 months and we are still nursing, although no longer exclusively of course... But with exercise and a healthy diet you will be well on your way to losing all of those baby pounds!!! I know how you feel though because I was the same way when I started out and I just stuck it out for baby (and bills!) And I was very surprised with how fast the

weight came off! So hang in there...:) GOOD LUCK!!! (Babycenter.com, 25 April 2011, para. 8).

The mom-to-mom recommendation centers on the master narrative of pediatric nutrition that privileges breastfeeding over formula feeding. Interestingly, 16 out of the 17 responses to the weaning and weight question directly advocated that the mother continue to breastfeed her child. Justification for the their recommendation included increased metabolism with breastfeeding, additional calories burned with breastfeeding, and the need to attend to other emotional issues, such as Postpartum Depression, rather than cease breastfeeding.

The problem therein lies with unrealized potentiality to transform the master narrative. Using online communities, seeking and providing advice via “mom answers,” and blogging afford mothers the opportunity to express aspects of their maternal feeding stories that contest biomedical discourse and the medicalization of motherhood. Instead of resisting the hegemony of the master narrative, maternal feeding stories provide further evidence of the master narrative’s power. While these stories are influenced by a number of factors such as interpersonal relationships or religious beliefs, the master narrative reverberates through the expressed intentions and actions of the mothers. Maternal feeding stories featured in *Parenting* and other baby care texts voice moderate naturalism uncritically and demonstrate how dominant health discourses become *fixed* in forms of everyday talk (Dutta & Zoller; 2008; Mumby, 1997). The biomedical experts undergirding moderate naturalism direct characters, particularly mothers, to conform to the feeding practices and characterizations that “determine (un)acceptable behavior”

(Bergemen, 2010, p. 47). If the plot of the master narrative is not challenged or altered in these virtual spaces, then the virtual spaces function as a means for peers to reinforce and complement moderate naturalism and role of authoritative texts within the family. As the roles of non-experts are displaced, in terms of the characterization of their advice, this generates a dyad in pediatric nutrition narratives. The dyad is comprised of the mother and authoritative texts. Mothers are held responsible for reading, understanding, and implementing the instruction within the texts that have authority for their particular pediatric nutrition narrative. The roles of fathers, grandparents, extended family, neighbors, friends, coworkers, and others are etched out in favor of the dyad. The authoritative texts are positioned to be the primary form of social support for mothers, which minimizes the roles and silences the voices of non-medical experts in the narrative.

With that said, who has authority and what constitutes an authoritative text shifts in the counter narratives. With these shifts in authority also come shifts in maternal feeding stories. Synthetic acceptance positions mothers expressing their maternal formula feeding stories as legitimate sources of feeding information and valuable-situated knowledge. Susan Barston's Fearless Formula Feeder blog and Facebook page is illustrative of the power of maternal feeding stories to resist moderate naturalism and biomedical authority. For example, Michelle's traumatic feeding story details her struggle with misdiagnosis of a painful breast abscess. Michelle describes two different referrals from her midwife/lactation consultant to, first, an obstetrician and, second, an obstetric nurse. In each case, Michelle received the same "try harder" advice to continue

breastfeeding through the pain. Michelle describes the doctors and nurses as “useless,” and describes the midwife, who challenged their decisions, as “amazing” (Barston, 19 July 2013, para. 14). Despite her expressed concerns over a lump in her left breast, she was not touched in the physical examinations. Like other maternal formula feeding stories featured on the blog, Michelle points to the limits of biomedical knowledge and a common assumption among medical practitioners that mothers need to try harder. For Michelle, the doctors and nurses assumed that she was experiencing either engorgement or mastitis, two common breastfeeding problems that generate pain in the breasts. Such maternal feeding stories circulate on blogs and in social media like the Fearless Formula Feeder. In doing so, the Voice of the Lifeworld paves the way for maternal feeding stories, like Michelle’s, to contest “breast is best,” biomedical certainty, and expertise.

Strict naturalism also features maternal feeding stories that shift authority to different characters than those within moderate naturalism. Taylor Newman blogs about her struggles with pediatricians and other medical doctors. Pointing out the limits of biomedical knowledge, Newman refers to her son’s allergies as “a mystery to our MD’s” (23 January 2012, para. 5).

Allergy tests turned up countless positive results, and after discovering that western docs wanted only to prescribe steroids and Benadryl – which didn’t help, and posed potential side effects – we found Traditional Chinese Medicine as our saving grace... Pretty crunchy right?” (para. 5).

She turned to raw milk, traditional Chinese medicine, organic foods, and other “crunchy” mothers for help in feeding him. Her maternal feeding story begins with

dependency on the same experts that are featured in moderate naturalism, but the story functions to challenge the dominance of these experts. Newman's blog links to other "crunchy" blogs and resources for green living, which further demonstrates how maternal feeding stories become reflective and supportive different types of authoritative texts. In sum, maternal feeding stories voice differing experiences and experts that align with their narrative constructions. These stories are multivocal. Furthermore, maternal feeding stories can reproduce the hegemony of moderate naturalism and the biomedical discourse in which it is steeped, but maternal feeding stories can also resist moderate naturalism and shift authority to other characters within pediatric nutrition narration.

Conclusion

In sum, Chapter V has concentrated on authority, specifically characters with the power to shape pediatric nutrition narration. Despite modest challenges to authoritative characters' credibility in synthetic acceptance and strict naturalism, medical science and medical practitioners are the key-supporting cast in pediatric nutrition narration. These characters position their instruction as definitive over what constitutes good parenting, which is not surprising given the research on the Voice of Medicine and the medicalization of motherhood. Through popular press articles, policy statements, baby-care books, and other media, authoritative characters describe medical research and practitioner opinions as trustworthy and valuable and describe lay advice as intrusive and risky. By undermining the credibility of lay advice, authoritative characters limit the role of non-experts within the narrative. Partners, family members, friends, neighbors, and coworkers are silenced, especially in the master pediatric nutrition narrative. Their

voices are relatively nonexistent with the exception of other mothers sharing their maternal feeding stories to reinforce the advice of authoritative characters. The irony is that authoritative characters demonize lay advice in the maternal social network, yet instruct mothers that they need their social network for feeding support. From my vantage point, I see that these authoritative characters have altruistic motives to advance feeding practices consistent with evidence-based medicine and scientific inquiry. However, their motives should also encompass the Life World of the mother.. With that in mind, this chapter culminates in a discussion of maternal feeding storytelling. As distinctive form of discourse across all three pediatric nutrition narratives, it is important to note that maternal feeding stories are told differently in different spaces and reflect different sets of expert characters. On one hand, maternal feeding stories within moderate naturalism point to the power of the master narrative over individual's storytelling. On the other hand, maternal feeding stories within the counter narratives point to resistance storytelling. Resistance storytelling challenges the indisputable authority of medical practitioners and biomedical knowledge, and it also opens up narratives to position other mothers in more prominent roles that provide social support for one another through their stories. Closing Chapter V introduces Chapter VI, which will be the final chapter in this study. Chapter VI will conclude by providing a summary of this work, detailing its contributions, noting its limitations, and exploring future directions.

CHAPTER VI

CONCLUSION

I'm not a nutritionist, but I play one in real life... Motherhood has a way of requiring you to get up to speed – *fast* – on subjects for which people actually train professionally. (I'm expecting my degrees in emergency medicine and transportation logistics to be arriving any day.) (Rocks in My Dryer, 2008 August 25, para. 1).

Nutritionist, risk manager, pediatrician, and master of the universe are apropos titles for the mothers depicted in pediatric nutrition narration. I too have felt the weight of totalizing motherhood as I type and click as fast as possible to search the Internet for information about “red, splotchy face and strawberries” or “how long pumped breast milk stays good at room temperature.” At times, I have asked myself, “Why don't I already know the answer to this question?” Other times, I have asked, “Is it really all that important that I find the answer to this question?” As this work draws to a close, I am sober-minded with regard to the maternal weight of responsibility represented in feeding stories and in nutrition instruction aimed at mothers.

This study set out to examine how pediatric nutrition instruction texts birth through 12 months construct master and alternative narratives that, in turn, determine what constitutes good and bad parenting. To do so, *Parenting* magazine articles and parenting.com written materials were analyzed along with secondary texts identified in Chapter II to create pediatric nutrition narratives. The resulting analysis is reflected in Chapters III, IV, and V. Generally speaking, the three narratives feature the maternal

role prominently emphasizing her empowerment to make familial decisions yet burdening her with the responsibilities to control the feeding process and product in conjunction with the narrative's aims. The postfeminist mother is prominently featured in Chapter III. More specifically, Chapter III teases out the characterization of the mother and peripheral characters, preferred feeding practices and motivations, and scenic and contextual constraints in relation to the master narrative – moderate naturalism. In pregnancy, mothers are inundated with messages that characterize their breasts and children as on a biological mission to breastfeed. The mother is responsible for self-education to make decisions that enable her breasts and child to fulfill their collective mission. The “breast is best” discourse undermines messages that argue maternal feeding choices are personal and made after carefully weighing research, expert recommendations, and advantages/disadvantages. Moderate naturalism presents breastfeeding, with limited combo feeding, as the only legitimate choice that good mothers can make. As mothers initiate and sustain breastfeeding, a problem-solution orientation is adopted to address conflicts to the breastfeeding plot (e.g. uncooperative breasts, changes in scene). Mothers are expected to determine the nature of the conflict, seek out information about the conflict, implement the recommended solution to solve the problem, and continue breastfeeding.

Moderate naturalism presents breastfeeding as a natural process of delivering a natural product but de-emphasizes the need for naturalism during the introduction of solid foods. Whereas natural feeding becomes a health enhancing and risk averse project in terms of breastfeeding, natural feeding becomes an unnecessary financial burden in

terms of introducing solid foods. Formula is featured as a sub-par breast milk substitute, but processed baby foods are described as safe and affordable ways to introduce children to a variety of foods and cultivate healthy eaters. While “natural” is a primary concern in the first 4-6 months, “natural” becomes less of a concern as solids are integrated into eating.

Moderate naturalism may be the master narrative endorsed by biomedical research, medical organizations, medical practitioners, and authors of instructional texts; however, there are two counter narratives that are in dialogue with moderate naturalism yet resist various aspects of it as well. Synthetic acceptance and strict naturalism are presented in Chapter IV. First, synthetic acceptance challenges the construction of good mother as the breastfeeding mother by legitimizing breastfeeding difficulties, normalizing formula feeding, and broadening the scope of feeding practices and products considered acceptable choices. In doing so, this counter narrative functions as an antagonism to the hegemony of moderate naturalism. Within synthetic acceptance the mother can achieve aims of totalizing motherhood through feeding education, control over the scene and feeding process/products, and formula-matching. Nevertheless, the good mother is described as beginning her feeding story within moderate naturalism and having to transition to synthetic acceptance. The transition to synthetic acceptance generates feeding stories that express maternal efforts to achieve the ends of moderate naturalism and maternal guilt for not being able to breastfeeding exclusively. Synthetic acceptance reads like a pseudo counter narrative and is contained through messages that communicate: 1) breastfeeding was initiated but unachievable and 2) mothers feel guilty

about their inability to sustain exclusive breastfeeding. The synthetic acceptance narrative is embedded in texts that feature moderate naturalism and feeding stories that lament the inability to accomplish moderate naturalism. Inevitably, the quantity of instruction supporting moderate naturalism overshadows synthetic acceptance. The dominance of moderate naturalism in parenting and baby care instruction means that alternative narratives must exist in separate spaces. The Moms Feeding Freedom blog, which critiques culture and research, and the Fearless Formula Feeder blog, which presents formula feeding stories, are two very different blogs that demonstrate how synthetic acceptance is constructed in its own space and can exist apart from the shadow of moderate naturalism.

The second counter narrative, strict naturalism, appears to overlap significantly with moderate naturalism in pregnancy and the first 4-6 months due to “breast is best” messages; however, strict naturalism positions the mother quite differently regarding her motivations. Strict naturalism characterizes mothers as highly educated about organics and health, domestically oriented, frugal, and environmentally active. In one sense, strict naturalism is empowering. Mothers are encouraged to be politically active, express their feeding stories and practices to one another, and protect the environment along with their family’s health through their domestic service – breastfeeding and making homemade-organic baby food. Moreover, strict naturalism may complement other facets of maternal identity – going green, resisting consumerism, or being a foodie. In another sense, strict naturalism reproduces traditional gender roles, in which the

mother's value is tied to domestic duties within the scene of home rather than employment outside of the home.

The maternal role in moderate naturalism, synthetic acceptance, and strict naturalism reveals the classed nature of pediatric nutrition narration. Moderate naturalism features mothers who are health literate, can enact a variety of professionalized roles within the home (e.g. nutritionist, risk manager), and have the resources to seek out services when they are unable to achieve breastfeeding goals on their own. Synthetic acceptance features mothers who are also health literate, exhaust every resource before transitioning from breastfeeding to formula feeding, and can afford the often expensive, perfectly matched formula for their baby. Strict naturalism features mothers who are health literate, are environmentally educated and active, have the resources to purchase the products necessary to make their own organic baby food, and have the leisure time to do so as well. Across all three narratives, good mothering depends on the mother's financial, social, and educational resources, which may not be accessible to mothers in lower socio-economic strata.

The politicized maternal role within the counter narratives has the potential to shift postfeminist individualized frameworks towards cooperative frameworks. On one hand, an individualized framework may acknowledge structural and socio-cultural issues shared by women (e.g. limited maternity leave for working mothers, demonization of formula feeding), but no plan for organized action is presented to overcome the issues. An individualized framework promotes postfeminism by placing the impetus on the individual mother to overcome the issue. Moderate naturalism promotes an

individualized framework and presents mothers as apolitical characters. As such, the maternal role is enacted by mothers, who educate themselves about feeding, implement feeding practices consistent with expert advice, and overcome complications to feeding by disciplining oneself. On the other hand, a cooperative framework politicizes the maternal role by situating the mother in concert with others who are voicing concerns related to structural and socio-cultural issues and working toward change to benefit the collective. Synthetic acceptance contests the apolitical mother by speaking out about the plurality of maternal feeding experiences, pointing to the limitations of moderate naturalism and its breastfeeding expectations, and questioning the extreme claims of breastfeeding benefits. In spite of synthetic acceptance's entanglement with moderate naturalism and limited quantity of texts, social media has opened up space for mothers to disseminate their counter narratives (e.g. Fearless Formula Feeder blog and Facebook page, Moms Feeding Freedom blog). Strict naturalism contests the apolitical mother by positioning the mother as an environmental activist. Her natural feeding practices and products are an expression of lifestyle choices that protect the environment and protect the family from processed and artificial products. As a "crunchy" mother, she is a member of a movement of people that are posting images of their homemade baby food, talking to mothers on the playground about breastfeeding, and speaking out for structural and socio-cultural issues to be addressed in a way to empower women to enact their maternal role within strict naturalism. The collective frameworks presented in synthetic acceptance and strict naturalism emphasizes the possibility for politicized motherhood.

Mothers may feel that, “Nursing is the bomb” (Thompson, 2010 September 8, para. 3), that they should “have zero guilt about” not nursing (Ruddy, 2010 February 9, para. 5), or fall somewhere in between. Mothers may question solid food instruction, accept and follow all of the rules, or fall somewhere in between. As expressed in their feeding stories, mothers are concerned about how others perceive them, and as my critique points out, these mothers may be perceived (self and other perception) quite differently based on how they feed their children. Significantly tied to these perceptions are the authorities or experts that are featured within the specific narrative. Second only to the maternal role, authorities, including authoritative texts like *Parenting*, play an important roles in pediatric nutrition narration. The master narrative affords power to biomedical research, the American Academy of Pediatrics, medical practitioners (e.g. pediatricians, lactation consultants, and nurses), and Le Leche League. These experts, cited within and authoring pediatric nutrition texts, isolate mothers from other characters by depicting lay advice as intrusive and risky. These experts may be god-like in the master narrative, but both counter narratives express respectful concerns as to their authority. Synthetic acceptance contests their “breast is best” mantra but uses the same experts to normalize formula feeding. Strict naturalism accepts the “breast is best” mantra but resists their insistence that organics are an environmental choice rather than a health choice. Furthermore, both synthetic acceptance and strict naturalism feature feeding stories that position mothers in a social support network that legitimizes lay advice rather than demonizing it. The consequentiality of these feeding stories draws attention to role possibilities of non-experts within pediatric nutrition.

Revisiting Parenting

At the outset, I framed this study in terms of the intersection of parenting, family/child nutrition, and narrative. By zooming out to study parenting, rather than just mothering, the goal was to redress neglect in the academy regarding fatherhood (Pleck, 2012) and to better understand gendered constructions of maternal, paternal, and parental (as a unit) roles. However, data analysis of the master and counter narratives demonstrated that the focal character in pediatric nutrition narration is the mother. In pregnancy, mothers are singled out as responsible for taking care of their bodies, which are described as on a biological mission to breastfeed. During pregnancy and postpartum, maternal decision-making constructs mothering in terms of her caretaking and nutritionist roles. Across narratives, maternal motivations and feeding practices may shift slightly, but in each narrative, the totalizing role expectations tied to mothering are evident. Therefore, I ask, “What are the implications of paternal roles in pediatric nutrition narration and the family?”

The paternal role in pediatric nutrition narration is relegated to supporting the mother’s feeding duties (both breastfeeding/formula feeding and solids). Instructional texts demystify “myths” that breastfeeding excludes the father by describing ways in which fathers may participate in other caretaking opportunities (e.g. rocking, bathing, diapering). Ironically, *What to Expect the First Year* authors Murkoff and Mazel (2010) exclude breastfeeding in their demystification of this myth. In other words, fathers can participate in breastfeeding by excluding themselves from breastfeeding. In actuality, descriptions of paternal breastfeeding support deny fathers participation in feeding.

Instead, paternal breastfeeding support is accomplished by engaging in non-feeding baby care. However, fathers are occasionally mentioned regarding pumping and formula feeding because bottles present the opportunity for other caretakers to feed the child. While the texts reviewed in this study address paternal bottle-feeding as an advantage, these messages are often buried in texts that assume a maternal audience and focus on breastfeeding. Synthetic acceptance is the only narrative that contests the supportive paternal role and celebrates the opportunity for consistent paternal feeding responsibilities. The introduction of solid foods also presents an opportunity for fathers to take a more active role in family nutrition and meal preparation. Yet again, texts assume a maternal audience and feature feeding stories from the maternal perspective.

I argue that subordinating the father to pediatric nutrition support (support is used in a different sense than expert support discussed in Chapter V) constitutes family nutrition and meal preparation patterns that perpetuate beyond the first year of life. As explained in Chapter I, a higher percentage of females attend to household duties (e.g. grocery shopping), nurturing roles (e.g. child feeding), and socioemotional management than do males despite their participation in the labor market (Alberts, Tracy, & Trethewey, 2011; Erikson, 2005; Gerson, 2012; Twiggs, McQuillan, & Feree, 1999). To address this, I posed the question, “In what ways do pediatric nutritional messages reproduce gender inequities in the division of domestic labor?” In effect, pediatric nutrition instructional texts target mothers in pregnancy and postpartum, reproduce maternal role responsibilities related to caretaking and nutrition, and set patterns for inequitable distribution of family/child nutrition duties.

What is not clear in the pediatric nutrition instructional texts is how fathers may accept and/or contest their subordination to supportive cast rather than leading male in their family's nutrition narrative. Nor is it clear as to how parents contest the gendered role expectations (paternal and maternal), negotiate for higher degrees of paternal participation in family/child nutrition in the first year, and manage embodied tensions such as work-life balance, public-private parental performances, and good-bad parenting with regard to pediatric nutrition. Texts present a one-dimensional characterization of fathers and, thus, neglect the political implications and embodied experiences of fatherhood. Narrative silences are communicative to scholars (Poirier & Ayers, 1997), but silences in the texts are also frustrating. Further inquiry into the paternal role may expand texts that are analyzed (e.g. fathering books rather than baby care and feeding books, father blogs, social media) and conduct interviews and/or focus groups with fathers. Of interest would be how fathering narratives are positioned in relation to the more dominant mothering narratives.

Contributions

As I began this study reviewing literature in Chapter I, the works of Linda Blum (1999), Ellie Lee (2007, 2008), Joan Wolf (2007, 2011), Christina Bobel (2001), Deborah Lupton (Schmied & Lupton, 2001), and Joyce Marshall (2011; Marshall, Godfrey, & Renfrew, 2007) were prominently featured as critical of pediatric nutrition. These academicians have extended pediatric nutrition research beyond medicine to investigate the experiences with and consequences of pediatric nutrition instruction, primarily breastfeeding and formula feeding. This study augments this research by

applying a narrative lens to pediatric nutrition through both the breast/formula milk stage and the introduction to solid foods. Moreover, the contributions of this study feature a number of practice-based recommendations to different sets of characters within the master and counter narratives. The discipline of health communication blends research with practice by finding ways in which to circulate health communication studies to audiences that can use the data to improve health experiences, relationships, and outcomes.

It [Health communication research] needs also to be seen by practitioners and policy-makers working in the situation about which we are writing. Thus, communication researchers must ensure that the implications of our work for professional practice and health education are explicitly delineated and made accessible to the clinicians and health professions educators who can best put them to practical use (Sharf, 1993, p. 39)

The subsequent recommendations - to those who can put them to practical use - function to address the final research question posed in Chapter I: “How can pediatric nutrition instruction be transformed to include a multiplicity of legitimized narratives?” Rather than providing a list of generalized recommendations, the following recommendations are targeted to specific characters, who have both the power and responsibility to act on these recommendations.

Recommendations Targeted to the AAP

Chapter V identified an array of expert voices in pediatric nutrition instruction. While a number of organizational guidelines and policies are noted in instructional texts

(e.g. World Health Organization's guidelines for baby friendly hospitals), the American Academy of Pediatrics (AAP) is the most prominent. Given the AAP's influence on pediatric nutrition instruction and the construction of the master narrative, I propose that the AAP address the medical lexicon of failure and demonstrate a greater flexibility in feeding recommendations. First, I propose a change in medical and familiar lexicon related to "lactation failure" or "failed Lactogenesis II." As referenced in Chapter IV, failure discourse is represented in both medical terminology related to lactation as well as feeding stories. In particular, failure discourse shifts breastfeeding responsibility onto the mother. Whether the reason for "failure" is attributed to maternal biology (e.g. hypoplasia - low prolactin levels) or to other factors (theoretically) within maternal control (e.g. stress/exhaustion), failure discourse features failed bodies. The mother's body betrays itself, failing to embody the symbol and function of perfected motherhood – the breastfeeding mother. The good mother is able to control and discipline her body, succumbing to totalizing motherhood for the sake of her child's well-being. The bad mother fails to realize this embodiment of motherhood. Failure discourse alienates mothers from their bodies and persecutes the maternal body, giving rise to expressions of guilt and justification for the cessation of breastfeeding and onset of formula feeding. This lexicon is not necessary in order to label lactation difficulties. Furthermore, attempts to switch from "lactation failure" to "insufficient milk supply" do not address the root problem related to the constructions of the maternal body as working and good or as not working and bad. I propose that "unrealized" is a less-loaded term than failure and connotes that breastfeeding goals were unfulfilled. "Unrealized lactation" or

“unrealized Lactogenesis II” shift the focus from a cause of goal failure – the maternal body – to the goal itself – breastfeeding. The AAP can initiate the change in the medical lexicon, which would have a snowball effect to its membership, biomedical research, and medical practitioners.

Next, I propose that the AAP increase flexibility in feeding recommendations, by expressly stating the safety and legitimacy of alternative feeding practices like formula feeding and organics. AAP policy statements are influential in determining the content of pediatric nutrition instruction texts. Taking a more reflexive stance and acknowledging limitations of biomedical research, the AAP could mitigate the dogmatism surrounding their recommendations. For example, the AAP should acknowledge breastfeeding research’s limitations to account for other variables that could affect health. This is incumbent upon the AAP because it is through their journal and other publications that biomedical research is disseminated and then translated into lay terms in instructional texts. The AAP has recently altered its solid food recommendations due to new biomedical research, which further signifies the need for increased flexibility rather than dogmatism. The influence of the AAP can legitimize a wider range of safe feeding practices and characterizations of good and bad parenting.

Recommendations Targeted to Medical Practitioners

In addition to the voice of the AAP, medical practitioners are repeatedly quoted in pediatric nutrition texts. Pediatricians, nurses, and lactation consultants are the most common categories of medical practitioners referenced. I propose to target medical practitioners with recommendations related to feeding education. Their instruction is

authoritative and has the potential to address critiques of limited formula feeding education, awareness of breast hypoplasia (low prolactin levels preventing lactation), and attention to solid food education. Practitioners should increase the frequency of formula feeding education to prepare that statistical majority of parents who will feed their child formula within the first six months. Increased education should enhance formula feeding legitimacy, thus legitimizing a wider range of feeding choices and acknowledging the various scenic, physiological, and/or contextual constraints on breastfeeding.

Additionally, medical practitioners should educate parents on breast hypoplasia and other factors that may make breastfeeding an impossibility for mothers. While mothers may know about many breastfeeding challenges (e.g. dry, cracked nipples), they may not know about them all or if the challenge can be overcome. Breast hypoplasia is not a feeding impediment that a mother can will her way through in order to breastfeed. Rather than reiterating “breast is best,” medical practitioners can help mothers by explaining the realities of breastfeeding impediments, especially physiological impediments like breast hypoplasia. In doing so, medical practitioners may circumvent infants losing too much of their birthweight before initiating formula and simultaneously reduce maternal guilt related to formula feeding. Finally, medical practitioners can address the neglect of solid food instruction. In spite of attention to questions related to “when” in moderate naturalism (e.g. determining readiness signs) and “how” in strict naturalism (e.g. how to shop for organics, how to steam and puree), the introduction of solid foods receives far less attention than breastfeeding/formula feeding instruction.

Given that these recommendations are subject to frequent changes (e.g. timing of egg and peanut butter introduction), heightened attention would be beneficial. Furthermore, this stage in eating, especially if the mother has been exclusively nursing, poses an opportunity for extended involvement in nutrition and baby care from other characters in the narrative. While frequency of solid food messages should be increased, practitioners must be careful to demonstrate flexibility in products and practices and to not undermine parents who have limited financial resources and/or who are concerned about artificial components added to foods. By increasing solid food instruction, practitioners may contribute to broadening the range of legitimate feeding practices/products and parenting characterizations/motivations.

Recommendations Targeted to Mothers

Considering the primary target of feeding instruction is aimed at mothers, it is not surprising that mothers would be targeted with recommendations stemming from this study. Maternal feeding stories are prominently featured across pediatric nutrition instruction. However, as analyzed in Chapter V, feeding stories often inadvertently undermine maternal authority, reproduce the disciplinary gaze of the Voice of Medicine, and fail to further involve other caretaking characters, especially fathers. Mothers should expose themselves to a wide variety of feeding instruction and stories to help them see pediatric nutrition from diverse perspectives. In turn, this should contribute to a multivocality of experiences and perspectives in the feeding stories that these mothers share. Feeding stories have the potential to transcend the postfeminist individualization of feeding in moderate naturalism, the failure and guilt-ridden discourse of synthetic

acceptance, and the elitist undertones of strict naturalism. Feeding stories have the potential to feature parents and the paternal role, rather than further conflating parenting with mothering. Furthermore, feeding stories can spur collective action to address women's rights issues tied to pediatric nutrition (e.g. enhance and extend postpartum lactation services, lobby for paid and extended maternity leave, and lobby for enhanced social services like WIC's Food Program). These recommendations are not simply about pediatric nutrition; they are bound up in cultural systems in which mothers need the support of authorities to make changes that will enable them to perform their maternal roles, need the support of one another, and also need the greater involvement of other characters. Overall, the proposed recommendations function to: legitimize the two counter narratives, distribute caregiving labor, distribute pediatric nutrition authority, reduce formula feeding guilt, change discourse of failure, legitimize a wider range of parenting contexts and characterizations, increase support for mothers regardless of pediatric nutrition narrative, change structures related to the tensions between scenes of work and home, and move from individualized motherhood projects to cooperative action.

Narratives function to help individuals explore possibilities – possible selves (Green, Brock, & Kaufman, 2004), possible health outcomes and behavior changes (Mattingly, 1998; Petraglia, 2007), and possible ideological and power shifts (Japp & Japp, 2005; Mumby, 1987, 2004). Therefore, I ask, “How can narrative possibility¹³ be

¹³ “Narrative possibility” is a term that appears throughout narrative research. With that said it is used in a variety of contexts and is not operationalized within the literature. I use the term “narrative possibility” to invoke a number of linked concepts that are referenced in this section. “Narrative possibility” invokes

integrated into pediatric nutrition narration?” The term “possibility” suggests: 1) discontentment with the status quo, 2) an improved future, and 3) openness to diverse approaches toward that future. Critiques of the master and counter narratives demonstrate that each narrative has its set of limitations in constructing plots and characterizations of good parenting. The proposed recommendations aimed at the AAP, medical practitioners, and mothers have identified ways to improve the status quo of pediatric nutrition narration. The aims of Chapters III, IV, and V were to expose and disrupt the powerful discourse of the master narrative and demonstrate the ways in which counter narratives resist its plot and characterizations. Possibility also connotes narrative openness rather than narrative closure. Narrative closure (referred to more broadly as discursive closure) presents the master narrative in definitive terms (Barge, 2004); whereas, narrative possibility opens to a diversity of narrative constructions. Narrative possibility is reflective of Boje’s (1995, 2001) description of ante-narrative, a term that implies that narratives are speculative and are open to a multiplicity of meanings. Narrative possibility suggests that instructional texts may be inclusive of a plurality of legitimate pediatric nutrition narratives and that counter narratives merit their own textual space. Narrative possibility assumes a positivity related to the future of pediatric nutrition instruction – the status quo is not indicative of a terminal state but simply a temporal state of moderate naturalism hegemony. As this section demonstrates, there are a variety of characters that can capitalize on narrative possibility and implement the proposed recommendations to achieve a change in the status quo, an

Boje’s (1995, 2001) concept of ante-narrative, and “narrative possibility” is also defined by what it is not – narrative closure.

improved future, and a diversity of approaches to good parenting in relation to pediatric nutrition.

Limitations

With all research endeavors there are noted limitations. With regard to this study, limitations include the sampling of texts selected for the study, the type of data being analyzed, and the narrowed focus on pediatric nutrition. First, the number of texts selected for this study was limited. As a researcher, I chose *Parenting* and parenting.com as my primary data set and added baby care books, cookbooks, selected blogs, and baby care resource websites to comprise a secondary data set. The data set was ideal for constructing the master narrative, but it was constraining and difficult when constructing counter narratives, especially synthetic acceptance. While there were two blogs, Moms Feeding Freedom and Fearless Formula Feeder blogs, that were clearly different types of discourse commensurate with synthetic acceptance, the ways in which these texts were written were dramatically different from the other texts used within the study. The Moms Feeding Freedom blog was primarily an expert voice expressing criticism of breastfeeding/formula feeding research and popular culture, and the Fearless Formula Feeder blog was primarily storytelling. The vast majority of texts analyzed in this study fit within a genre of feeding instruction and read in a “how to” manner, even if they were infused with stories and critique. This was also true of the 100% Natural Parenting Blog, except this blog had a number of posts with sets of feeding recommendations and directions. Furthermore, limiting texts to those that fit within the genre of pediatric nutrition instruction birth through 12-months restricted me from

including other popular texts that may reference pediatric nutrition. For example, Freichs, Andsager, Campo, Aquillino, and Dyer (2006) included magazines like *Redbook*, *Good Housekeeping*, *Cosmopolitan*, *Essence*, and *Ebony*. This diverse set of magazines enabled the authors to examine pediatric nutrition messages that spanned different genres and different audience segments (e.g. *Essence* and *Ebony* were the two highest-circulated magazines to African American females at the time of their study). Even within my set of texts, the texts themselves referenced other popular press articles about pediatric nutrition published in *Redbook* and the *New York Times*. These limitations point to future directions for research that may lead to expansion of the genres of pediatric nutrition messages included in the study.

Another noted limitation of the sampling of texts is related to range of dates of *Parenting* articles. My study is limited to 15 year time span. Foss's (2010) study of *Parents' Magazine* breastfeeding/formula feeding articles spanned 77 years, and her collaborative content analysis (Foss & Southwell, 2006) of *Parents' Magazine* breastfeeding articles spanned 28 years. In each of these studies, Foss was able to note trends as they fluctuated over time due to the longitudinal data. While my study was not focused on changes and shifts in pediatric nutrition narration over time, such a focus may be a future direction. Follow up work on this study may look at a broader range of dates so as to be able to note the timeline of master and counter narrative development as well as the presence of narratives that are no longer reproduced in discourse. While the academy has well documented shifts in health recommendations and cultural perceptions of breastfeeding/formula feeding over time, the same cannot be said of the introduction

of solid foods. Longitudinal analysis may increase our understanding about this chronological period and characterizations of parents over time.

Second, the type of materials analyzed limited this study. I elected to not use mixed methods, and therefore, my materials were limited to texts that communicated pediatric instruction during the first year. In making this choice, I did not interview families to gather their stories about pediatric nutrition in the first year. Whereas the texts often silenced fathers and other caregivers, interviewing these characters would give me access to their experiences. Interviewing parents would have helped understand how they negotiate feeding decisions, co-construct parental roles and responsibilities, and reproduce and resist gendered constructions of those roles regarding child feeding. This limitation also implies a future direction for research, which will be explored in a subsequent section.

Third, the narrowed focus on pediatric nutrition became a limitation in the construction of strict naturalism. The intertextuality of narratives came to a head in discussions of strict naturalism in relation to 1) broader sets of parenting practices associated with natural lifestyles and 2) foodie culture. Analyzing the 100% Natural Parenting blog on parenting.com and perusing through the links to like-minded blogs from Parenting's website and the Natural Parenting Network's website, I quickly surmised that organic food was one choice among many lifestyle choices that parents make regarding naturalism. Strict naturalism intersects with cloth diapering, green cleaning products, and alternative medicine. Additionally, the domestic adherence to homemade baby food intersected with maternal identity as a foodie or craftiness.

Further attention to these intersections of strict naturalism with other lifestyle choices would make an intriguing study into the postfeminist paradox of domesticity and empowerment.

Future Directions

Strength of any scholarship is the further inquiry which it inspires. For me, this study has heightened my attention to several follow up studies – some of which are alluded to in the limitations section but others of which are not. First, future research may extend narrative analysis of pediatric nutritional messages to encompass visual communication. Yamasaki, Sharf, and Harter (in press) and Sharf, Harter, Yamasaki, and Haidet (2011) note the rarity of visual narrative sources yet demonstrate the utility of visual forms of data, especially photography. In the study of pediatric instructional messages, visual images coincide with the traditional text-based messages. Perusing the pages of *Parenting*, readers not only receive verbal messages about feeding their children, but they also view photographs of parents modeling the feeding practices and products that facilitate implementation of practices. Infant care and pediatric nutrition manuals even feature diagrams, photographs, and graphics to illustrate parenting advice. Moreover, homemade baby food books show bright, attractive photographs of step-by-step preparation processes, super foods, and parents and their children enjoying the process and products.

From a behavior change perspective, visual data may add understanding as to the influence of the master narrative on parents feeding practices. Research questions such as the following may guide analysis. How do visual data enable or constrain self-

efficacy for parents to overcome conflicts within parenting plots? How do visual data construct permeability and/or stability between master and counter narrative plots? How do models of infant feeding reproduce or resist the master narrative? From a critical perspective, visual data may help inquiry into the classed, raced, and gendered messages about the characters and contexts of these plots. Research questions could extend exploration into pediatric nutrition as a white, middle-class motherhood project. How is socio-economic class implicated in pediatric nutrition visualizations? How are ethnic and racial groups represented visually in pediatric nutritional texts? How do messages about parenting and infant care become gendered in photography? Furthermore, the search for a more diverse representation of class, race, and gender in visual formats may shed light on the ways in which parenting plots are disseminated to more diverse audiences. For example, to find representations of Hispanic families in pediatric nutritional instruction, do you have to find sources that are targeted specifically to Hispanics or are there representations in mainstream publications like *Parenting* magazine or *What to Expect the First Year*?

Second, future research may extend data collection from instructional written materials to in-depth interviews, focus groups, and participant observation. Parental narratives would shed light on the ways in which parents reproduce and resist the characterizations of their roles and actions of the plot of the pediatric nutrition master narrative. In what ways do parents narrate gender roles in feeding practices? What motivations for infant feeding practice preferences are expressed in parents' storytelling? How do parents justify their pediatric nutritional choices? How do parents negotiate

decision-making and implementation of feeding practices in their everyday social interaction? How may narrative components such as scene, context, or other characters affect negotiation? What instructional texts are more or less influential in parents' infant feeding perceptions and choices? How do other sources (i.e. relatives, friends, doctors, entertainment) of pediatric nutrition instruction affect parents' perceptions of instructional messages? Are there other narratives embedded in and narrated through experience that are silenced in instructional texts?

Another plausible extension of this study would be to seek out parents whose feeding practices and ideologies fit within the three narratives. A sampling from each of the narratives will provide insight as to how parents enact and narrate their experiences similarly and differently from the texts. I conjecture that their identification with one or more of the three narratives is not as essentializing and one-dimensional as instructional texts portray. They are likely to voice a plurality of narrative constructions and meanings giving rise to new narrative understandings of parenting and pediatric nutrition.

Given implications related to class, qualitative inquiry should direct attention to parental populations in lower socio-economic strata. Working in conjunction with local WIC offices, health and human service offices that house food stamp and welfare programs, and free clinics, access could be gained to these parents with aim to better understand their pediatric nutrition stories from their subject positions. Such research may be designed in such a way to promote social justice for these families and advocate for changes in incentive systems that, in turn, penalize families for formula feeding.

Furthermore, it would be interesting to see how parents utilize the farmer's market food program through WIC, which is a relatively recent addition to the WIC Food Program that permits mothers to shop at local farmer's markets in addition to grocery stores. It may be that strict naturalism's underlying environmentally conscious ideology is becoming less elitist and more accessible, or it may be that institutional attempts to enhance access to organic and locally grown produce is underutilized. Another point of access to lower SES may be through community services for single parents and low-income parents that provide labor, delivery, and child care education.

In addition to collecting qualitative data from parents, medical practitioners would add another layer of understanding as to how pediatric nutrition instruction is narrated. The American Academy of Pediatrics' has policy statements on pediatric nutrition that aim to influence the types of messages pediatricians give their patients and families. However, it would be interesting to observe how pediatricians perform their role in pediatric nutrition instruction in the clinical scene. Research questions could center on 1) the ways in which pediatricians (de)legitimize master and counter narratives, 2) the messages privileged by the pediatrician versus other sources of instruction, and 3) how pediatrician's messages vary based on communication exigencies (i.e. parental concerns, relationship with parents, developmental markers, etc...).

As this study draws to a close, I am reminded that pediatric nutrition birth through the first 12-months is cast as a vital stage in child development. The weight of maternal responsibility for enacting expert instruction and achieving moderate

naturalism is consequential for mothers and their loved ones. With that said, I am also reminded that pediatric nutrition is not the only marker of good mothering and that children thrive due to and in spite of a variety of factors. I was a formula fed preemie and turned out a healthy 35-year old. I consumed my share of processed baby food, table foods, and juice, and I lived to tell the tale. One parenting.com blogger puts it this way, “Anyway, I ate chicken curry as an infant and here I am alive and blogging” (Thompson, 2010 May 26, para. 4). The focus should not remain solely on the natural degree of the feeding practice or product nor should the focus remain on the extent to which the mother adhered to expert advice. Instead, the focus should broaden to include how feeding responsibilities may be distributed among caregivers, how parents negotiate feeding roles equitably, and how patterns may emerge that value both maternal and paternal roles within the scenes of home and work.

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APPENDIX A

PEDIATRIC NUTRITION INSTRUCTIONAL TEXTS

Primary Data Set			
Source	Search Term	Number of Articles	Time Span
Parenting Magazine	Infant Feeding	19	1996-2012
	Solid Foods	20	1996-2012
	Baby Food	69	1996-2012
	Breastfeeding	114	1996-2012
	Formula	25	1996-2012
Parenting.com	Feeding section	80 (additional articles were found using search terms but are not included in total)	2012
Secondary Data Set			
Source Type	Source	Author(s)/Sponsor(s)	Published Date
Book	<i>On Becoming Baby Wise: Giving Your Infant the GIFT of Nighttime Sleep</i>	Ezzo and Robert	2012
	<i>Mayo Clinic Guide to Your Baby's First Year</i>	Mayo Clinic	2012
	<i>The Baby and Toddler Cookbook: Fresh, Homemade Foods for a Healthy Start</i>	Ansel and Ferreira	2011
	<i>The Baby Book: Everything You Need to Know about Your Baby from Birth to Age Two</i> (revised edition)	Sears, Sears, Sears, and Sears	2013
	<i>The Baby Food Bible: A Complete Guide to Feeding Your Child, from</i>	Behan	2008

	<i>Infancy on</i>		
	<i>The Best Homemade Baby Food on the Planet</i>	Knight and Ruggiero	2010
	<i>What to Expect the First Year (2nd edition)</i>	Hathaway, Eisenberg, and Murkoff	2003
	<i>Your Baby's First Year (3rd edition)</i>	American Academy of Pediatrics edited by Shelov	2010
	<i>Your Pregnancy Week by Week (5th edition)</i>	Curtis and Schuler	2004
Booklets	<i>A Miracle in the Making</i>	Hayman	2002
	<i>The Physician's Pocket Guide to Breastfeeding</i>	Texas Department of State Health Services	2001
	<i>Your Life After the Baby is Born: The Post Partum Period</i>	Neimark	2001
Pamphlets/ Brochures	<i>Speak Up: What You Need to Know about Breastfeeding</i>	The Joint Commission	2011
	<i>Breastfeeding Your Baby: Making the Decision Together</i>	United States Department of Agriculture, Food and Nutrition Service	2002
	<i>Fathers Can Support Breastfeeding</i>	United States Department of Agriculture, Food and Nutrition Service	2002
	<i>Busy Moms: Breastfeeding Works around my Schedule</i>	United States Department of Agriculture, Food and Nutrition Service	1996
	<i>WIC's Circle of Care for Breastfeeding Mothers</i>	United States Department of Agriculture, Food and Nutrition Service	1996
	<i>Embarrassment: Don't Shy Away from Breastfeeding</i>	United States Department of Agriculture, Food and	1996

		Nutrition Service	
	<i>Encouragement: Give a Breastfeeding Mom Your Loving Support</i>	United States Department of Agriculture, Food and Nutrition Service	1996
	<i>Moms Helping Moms – Meet Your WIC Breastfeeding Peer Counselor</i>	United States Department of Agriculture, Food and Nutrition Service	1996
Resource Websites (contain articles, product links and/or shopping, blogs, and virtual communities)	Baby Center at www.babycenter.com	Baby Center, L.L.C.	2013
	Baby Zone at www.babyzone.com	Disney Corporation	2013
Blogs	Moms Feeding Freedom at www.momsfeeding freedom.com	Kahn, Dehn, and Sillman	2007-2013
	Fearless Formula Feeder blog at www.fearlessformula feeder.com	Barston	2010-2013
	The Honest Co. at www.honest.com	The Honest Company	2013
	100% Natural Parenting Blog posted on www.parenting.com	Newman	2011-2013

APPENDIX B

MASTER NARRATIVE OF PEDIATRIC NUTRITION

Pregnancy: Chronological Period Marked by Breastfeeding Education and Mother as Decision Maker

Prepare for Child Feeding

Become Educated about Breastfeeding

- Learn about breastfeeding benefits

- Choose to breastfeed as it is the mark of good parenting

Purchase Products to Facilitate Breastfeeding

Birth through 4-6 Months: Chronological Period Marked by Exclusive Breastfeeding Implementation and Mother as Problem Solver

Breastfeed Exclusively with Limited Formula Supplementation

- Put Baby to Breast Immediately

- Inform Hospital to not Supplement in Nursery

- Monitor Baby's Weight and Diaper Production

- Persevere through Breastfeeding Challenges

- Pump and Store Milk Safely

- Supplement with Vitamin D if Necessary

4-6 Months through 1 Year: Chronological Period Marked by Cultivating a Healthy Eater and Mother as Risk Reducer

Introduce Solid Foods

- Continue to Breast or Formula Feed in between Meals

- Introduce Rice Cereal at 4-6 Months

- Puree Solid Foods or Purchase Baby Food

- Work up to 3 Daily Meals and 2 Daily Snacks

- Reduce Risks

 - Reduce Food Allergy Risks

 - Reduce Negative Perceptions of Eating Risks

 - Reduce Picky Eater Risks

 - Reduce Safety Risks

Introduce Juice

- Introduce 4-6 oz. Daily 100% Real Fruit Juices

- Reduce Tooth Decay Risks

- Begin to Wean from Bottle

Introduce Vitamins/Supplements as Needed

APPENDIX C

MUTUAL BENEFITS OF BREASTFEEDING

Benefit to Child	Exemplary Quotation
Prevent Obesity	“Breastfeed if you can. ‘It reduces the risk of fatness in a child,’ says Tufts University nutrition professor Susan Roberts, Ph.D., coauthor of <i>Feeding Your Child for Lifelong Health</i> . Breastfeeding lets an infant regulate how much he eats – and the milk itself may help control appetite” (Hermann, 2002, p. 29).
Protect Against Environmental Pollutants	“Breast milk itself may protect against contamination: A Dutch study of around 400 infants found that while exposure to polychlorinated biphenyls (PCBs) in utero could cause motor and cognitive problems at age 6, it showed up only in formula-fed kids – even though breastfed babies were exposed to PCBs in the milk. ‘Breastfeeding counteracts the adverse developmental effects of PCBs,’ says researchers” (Barnett, 2002b, p. 28).
Protect Against Ear Infections	“Babies nursed exclusively for four to six months are 50 percent less likely to get ear infections than those who aren’t. This may be because breast milk has antibodies that inhibit bacterial infections, notes Ja Gordon, M.D., a pediatrician and member of the La Leche League International Health Advisory Council” (Lathrop, 1999, p. 33).
Protect Against Respiratory Infections	“Breast milk also inhibits the growth of bacteria in the lungs, mouth, and nose. A 1998 study showed that infants solely breastfed for six months have shorter episodes of respiratory illness (pneumonia, runny nose) during that time” (Lathrop, 1999, p. 33).
Protect Against Common Cold and Flu	“By the time that you start showing any symptoms, your baby has probably already been exposed to the illness. But by breastfeeding, you’ll be able to protect him: The antibodies that your immune system creates in order to fight a specific infection pass directly into your breast milk. If you stopped nursing now, your child would be more likely to get sick” (Breastfeeding when you’re sick, 2002, p. 33).
Protect Against Childhood Asthma	“Researchers have found that just four to six months of breastfeeding helps protect against childhood asthma” (Barnett, 2002a).
Protect Against Milk Allergy	“Because most formula is derived from cow’s milk, infants who are formula-fed may have a higher risk of developing a milk allergy than those who are breast-fed” (Mayo Clinic, 2012, p. 61).

Benefit to Child	Exemplary Quotation
Protect Against Post-Vaccine Fever	“Breastfeeding may give baby a boost when it comes to routine vaccinations, according to a new study from Italy that suggests breastfed infants are less likely to develop a fever following routine immunizations... It’s unclear from this study exactly how breast milk wards off fever, but researchers think anti-inflammatory properties of human milk or even the act of nursing itself could be factors” (Tourville, 2012).
Reduce Risk of Sudden Infant Death Syndrome	“A large German study published in 2009 found that breastfeeding – either exclusively or partially – is associated with a lower risk of sudden infant death syndrome (SIDS). The researchers concluded that exclusive breastfeeding at 1 month of age cut the risk of SIDS in half” (Babycenter.com, 2012a).
Enhance Neurodevelopment	“Various researchers have found a connection between breastfeeding and cognitive development. In a study of more than 17,000 infants followed from birth to 6 ½ years, researchers concluded from IQ scores and other intelligence tests that prolonged and exclusive breastfeeding significantly improves cognitive development” (Babycenter.com, 2012a).
Enhance Jaw and Teeth Development and Protect Against Cavities	“Babies who nurse have to work harder than bottle-fed babies to draw liquid into their mouths. This strengthens their jaw muscles, helps shape their pallet, and promotes better tooth alignment... Breastfeeding infants draw milk towards the back of their throat, away from their teeth. Formula from a bottle tends to pool in a baby’s mouth, exposing gums and teeth to more sugar. Special enzymes in breast milk (those are absent in formula) also reduce the build-up of decay by quickening the breakdown of milk sugars” (Elovson, 2012).
Cultivate a Healthy Eater	“Need one more reason to consider breastfeeding your baby? Research suggests it’s then easier to introduce solids, because infants who nurse are more willing to try new foods” (Passing on good taste, 1998/1999, p. 284).
Benefit to Mother	Supportive Quotation
Decrease in Postpartum Uterine Bleeding	“Breastfeeding right away benefits the mother by causing the uterus to contract, thus reducing the amount of uterine bleeding” (Shelov, 2010, p. 50).
Release of Hormones Oxytocin and Prolactin	“When you nurse, especially between the third and sixth months, there’s a surge of the hormones oxytocin and prolactin, which produce a loving sensation and intense feelings of happiness” (Nursing’s feel-good effect, 2004, p. 68).

Benefit to Mother	Supportive Quotation
Reduces Risk of Breast Cancer	“Exclusive breastfeeding reduces fluctuations in estrogen. Since estrogen can stimulate some cancers, the less you’re exposed to it, the better. Partial nursing may not have the same benefit” (Boone, 2004, p. 56).
Versatility of Breast Milk as Natural Antibiotic	“Your breast milk can sub in when your child (or you) has a minor cut, thanks to the milk’s natural antibiotics that fight infections. Just express a little onto a cotton pad and dab it on your child’s skin. Then air-dry the cut and bandage it, says Sandy Johnson, M.D., a dermatologist in Forth Smith, AR, who also recommends breast milk for baby acne, diaper rash, cradle cap, dry skin, and even mild eczema” (Lynch, 2008, p. 43).
Decrease of Financial Burden and Increase in Convenience	“Formula is costly, which is a concern for some parents” (Mayo Clinic, 2012, p. 59). “Breast milk is free, always the right temperature, and the fat content even changes according to the baby’s needs” (36 tips for breastfeeding success” (Hays, 2012).
Effect to Body Shape	“It gives me boobs and it takes my thighs away! It’s sort of like natural liposuction. I’d carry on breastfeeding for the rest of my life if I could” stated <i>Parenting</i> reader Helena Bonham Carter (Parenting, 2004, p. 29). “Breastfeeding and gradual weaning may help redeposit fat into the breasts and return them to more of a prepregnancy appearance” (Meitner, 2012).
Intangible Reward	“It’s worth it – after all, nursing a baby is one of the precious rewards of motherhood” (Neifert, 2002).

APPENDIX D

BREASTFEEDING CHALLENGES

Obstacle Attributed to Child		
Obstacle Type	Recommendation	Supportive Quotations
Child Congestion	Change Feeding Position and Treat Congestion	“Try holding her in an upright position while you feed her. ‘Your baby may breathe more easily when she’s propped up,’ says Linda Black, M.D., a pediatrician in St. Louis Park, MN. You might also want to nurse her for shorter periods at more frequent intervals to make sure she’s eating enough. If she’s really stuffed up, loosen congestion with a nasal saline solution. A bulb syringe can then help suction mucus from her nose, but use it only when necessary: Over suctioning can irritate nasal tissue and cause even more swelling and congestion” (Nursing a stuffy baby, 2001, p. 33).
Shallow Latch	Change Position and Elongate Nipple	“Are your nipples sore? Yes. Baby could have a shallow latch or might be in an odd position. Try leaning back and putting her tummy down on your chest during feeding” (Crane, Heyworth, & Clower, 2012, p. 78). “Hold your breast well back on the areola with your fingers underneath and thumb on top; press your thumb and fingers together while you push back toward your chest wall” (Sears & Sears, 2000, p. 125).
Premature Birth	Pump, Freeze, and Follow Medical Recommendations	“If you’ve given birth prematurely, your breast milk is ideal for your baby’s needs; it’s rich in antibodies and certain nutrients. But not all preemies can breastfeed successfully, and some need extra protein, iron, calcium, and vitamins A, D, and E to help them grow and gain weight... Moms should begin to pump and freeze their breast milk as soon as their baby’s born so their milk supply doesn’t dry up” (Coutts, 2001, p. 32).

Obstacle Type	Recommendation	Supportive Quotations
Multiples	Follow Premature Birth Guidelines, Nurse One at a Time, Introduce Dual Nursing	“Breastfeeding one baby can be a challenge, so two or more may seem truly daunting... Once they’re able to latch on, nurse your babies one at a time until you all get the hang of it. Then either continue feeding each one separately or experiment with these two-at-a-time positions, which will make feedings go more quickly and spare you a fretful, hungry baby-in-waiting” (Pepper, 2001, p. 157).
Biting	Relieve Sore Gums, Communicate Inappropriateness and Continue Nursing	“Before feeding, have your baby relieve his gums on a cold washcloth, frozen rubber teething ring, or even your fingers so that he’ll be less likely to gnaw on your breasts” (Sears, 2003, 44). “When I’ve been nipped, I immediately take my child off my breast, sit him up, and say ‘No biting!’ in a stern voice. I wait a few seconds to put him back on, and if it happens again, I repeat the routine” (McCarthy, 2007, p. 50).
Distractions to Baby	Remove Distractions	“KEEP HIM FOCUSED. While nursing, a baby can become interested in voices, sudden noises, and activity around him.” Therefore, “whenever your baby seems distracted, simply remove him from the breast; he may be content to end the nursing session then and there. If he’s still hungry, find a less stimulating place to feed him, such as a dimly lit, quiet room... Or throw a small blanket over your shoulder to block his view” (Elting, 1999, p. 195).
Nursing Strike	Determine Cause (e.g. new scent, change in routine), Feed Expressed Milk, and Continue Breastfeeding	“Regardless of what’s causing a strike, give your baby lots of skin-to-skin contact and quiet opportunities to nurse when she’s calm. Some parents reach for a bottle when their infant’s on strike, but since this could cause weaning before you’re ready, feed your baby expressed breast milk from a cup until nursing is reestablished” (Fram, 1998, pp. 155-156).

Obstacle Type	Recommendation	Supportive Quotations
Nursing Gymnastics	Change Nursing Holds	Use the cradle and clutch holds to minimize the baby's opportunities to squirm and kick (Sears, 2012).
Obstacle Attributed to Mother		
Obstacle Type: Biological	Recommendation	Supportive Quotations
Maternal Weight Management Goals	Moderate Exercise	<p>“Nursing moms may want to wait at least four to six months after childbirth before going on a diet. Even though there's some evidence that you can safely shed about a pound a week without harming your milk supply, it's best to hold off until your baby starts to eat solid foods and no longer depends on you as his sole source of nutrition... Your best bet: Stay active” (Krum, 2000, p. 45).</p> <p>“If you work out more than two hours daily, feed your baby beforehand and drink plenty of fluids” (Lee, 2004, p. 76).</p>
Maternal Illness and Pharmaceutical Consumption	Limit Intake, Schedule Medicine, and Consult with a Doctor/Pharmacist	<p>“Women who breastfeed are often told to avoid medications, as a small amount of any drug will get into breast milk. But when you must take medicine, it's wise to coordinate it with the baby's schedule – for instance, take it just after he nurses or before his longest sleep – to minimize its effects” (Weinstock, 2000, p. 45).</p> <p>“If you're breastfeeding and taking a narcotic like codeine or Percocet to ease the pain of a C-section, episiotomy, or another condition, talk to your doctor. The Food and Drug Administration is now warning nursing moms to be cautious about taking these drugs, after the recent death of a breastfed baby. In some women, the drugs can be metabolized into morphine so quickly that an infant may suffer an overdose after drinking his mother's milk” (Sprinkle, 2008, p. 78).</p>

Obstacle Type	Recommendation	Supportive Quotations
Birth Control	Use Progestin-only Birth Control or IUD	“You may want to opt for the Pill, the NuvaRing, or an IUD instead of, say a diaphragm. You’re breastfeeding. Any birth control with estrogen in it can reduce your milk production, soopt for a progestin-only pill or an IUD” (Bender, 2006, p. 65).
Fatigue from Nighttime Feedings	Feed and Demonstrate Night and Day Differences	“Frequent night nursings can be pretty rough on you, but they’re actually a good thing, especially in the first six months... You can try to make sure she goes back to sleep quickly: Don’t turn on the lights, don’t play with her, and forgo a diaper change unless she’s soaked or uncomfortable” (Miles, 2003, p. 188).
Flat or Inverted Nipples	Pinch Nipple, Pump First, Use Breast Shields and/or Reverse Pressure Softening	“Flat nipples don’t stand out much from the surrounding area (called the areola) and don’t protrude when stimulated. That sometimes can make it difficult for your baby to latch on and breastfeed. Inverted nipples retract or pull inward when stimulated” (Babycenter.com, 2011b).
Sore Nipples	Attend to Nipples and Alternate Nursing Positions	“When your baby first latches on, you’re going to feel some pain – at least until you and your infant get the positioning right, typically after a few days, says Dr. DiSanto. If your nipples become sore, try applying expressed breast milk or a lanolin cream to them, exposing them to the air between feedings, and changing your baby’s position at each feeding. Begin nursing on the least-sore breast – that’s the one your baby will suck the hardest” (Lanigan, 2000, p. 199). “Slather your breasts with peanut butter, top with birdseed and stand in your backyard” (Balmain, 2012).

Obstacle Type	Recommendation	Supportive Quotations
Clogged Milk Ducts	Empty Affected Breast, Apply Warm Compress	“Because blocked ducts can lead to an infection, you should treat the problem right away. The best way to open up blocked ducts is to let your baby empty the affected breast, offering that breast first at each feeding. If your baby doesn’t empty the affected breast, express milk from it by hand or by breast pump. It may also help to apply a warm compress before nursing and to massage the affected breast” (Mayo Clinic, 2012, p. 57).
Mastitis	Continue to Nurse/Pump, See a Doctor	“The symptoms of mastitis include severe soreness, hardness, redness, heat, and swelling over the affected duct, with generalized chills and usually fever of about 101°F to 102°F – though occasionally the only symptoms are fever and fatigue. Prompt medical treatment is important, so report any such symptoms to your doctor immediately. Prescribed therapy will include antibiotics and possibly bed rest, pain relievers, and heat applications. Though nursing from the affected breast will be painful, you should not avoid it. In fact, you should let your baby nurse frequently to keep the milk flowing and avoid clogging” (Murkoff & Mazel, 2010, p. 88).
Thrush or Yeast Infection	Sterilize and Cleanse Objects that Touch Breasts, See Doctor for Treatment	“Thrush is another name for a yeast infection. When breastfeeding, if either you or your baby develops a yeast infection, you will both be affected and should both be treated” (Iovinelli, 2012).
Maintaining and Increasing Milk Supply	Nurse/Pump Frequently, Maintain Healthy Diet, and Make Yourself Comfortable	“Two to three capsules [of fenugreek], three times a day” is recommended to increase milk supply within 48 hours (Michels, 2000, p. 176).

Obstacle Type: Socio-emotional or Perceptual	Recommendation	Supportive Quotations
Perceiving Hunger Cues Accurately	Monitor Baby's Head Movements, Hand to Mouth Movements, Cries, and Schedule	Early hunger cues include: "the baby's head moves toward the mother's voice, and the baby's mouth opens; the baby smacks its lips and sticks out its tongue; the baby's hands seemingly move at random; the baby's fists find its mouth; if not attended, the baby makes even more exaggerated motions; the baby begins to fuss" (Texas Department of State Health Services, 2001, pp. 22-23). Late hunger cues include: "the baby furrows its brow; the baby open its mouth wide, and its head moves frantically from side to side; the baby clenches its fists, seeking its mouth with them; the baby starts crying, which is a <i>very</i> late hunger cue" (emphasis in original, p. 23).
Socio-emotional Reservations (general)	Seek Social Support, Continue to Breastfeed	"West urges moms to seek out other moms for added support and help overcoming emotional reservations" (Meitner, 2012).
Maternal Feeding Responsibility	Continue to Breastfeed, Seek Assistance with Other Baby Care Tasks	Addressing the concern that, "It will all be on me," Meitner (2012) retorts, "Only if you let it be. Enlist your partner's help for diaper changes, baths, burping and cuddle time. When she's about 6 months old, dad can help by feeding baby her first solids."
Obstacle Type: Scene-based	Recommendation	Supportive Quotations
Return to Work	Schedule Milk Expression (Pumping) and Plan Effectively	"I blocked in 20 minutes of pumping time twice a day on my computer's calendar so that I wouldn't be double booked with meetings," said Raquel Karls to <i>Parenting</i> (Parenting, 2002, p. 72).
Feeding in Public	Continue Breastfeeding in Public Despite Discrimination; Learn Discreet Methods to Increase Comfort	"Despite the cheerleading and awesome work of groups like La Leche League and Best for Babies, and celebrity breastfeeding endorsements like that of Gisele Bundchen, nursing mothers still face tremendous roadblocks. After some early struggles, I was able to nurse relatively comfortably even in public (thank you, Hooter Hider!)" (Melanie at Parenting.com, 2010). "But with practice, you can become confident

		<p>feeding your baby almost anywhere. Some tips: Opt for a bra with a release mechanism that's easy to manipulate with a single hand. Put a receiving blanket or nursing shawl over your shoulder to shield your baby from public view, or use a sling, which lets your newborn breastfeed out of sight while you carry him. Wear two -piece outfits... Before venturing out in public, practice nursing in front of a mirror to get a feel for doing it discreetly" (Neifert, 2012).</p>
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APPENDIX E

PEDIATRIC NUTRITION NARRATIVE COMPARISON

	Moderate Naturalism	Strict Naturalism	Synthetic Acceptance
Educational Messages Targeted at Parents	The only acceptable infant feeding choice is breastfeeding because it is mutually beneficial.	The most acceptable feeding choice is breastfeeding because it is the purest, most natural source of nutrition. The introduction of solid foods is equally, if not more, important and requires specialized knowledge about organics.	Breastfeeding and formula feeding are acceptable forms of infant nutrition, but formula feeding moms will be faced with feelings of guilt and judgment for their choice.
Primary Feeding Method Birth to 4-6 months	Exclusive breastfeeding; limited formula supplementation	Exclusive breastfeeding preferred; Organic formula acceptable	Initiate breastfeeding; Exclusive formula feeding within first 4-6 months
Underlying Motivations for Feeding Decisions Birth to 4-6 Months	Informed decision-making to adhere to expert advice, optimize health of child, and provide safe food source	Informed decision-making to provide natural, chemical/additive/pesticide free forms of nutrition	Informed decision-making to optimize physical and mental health of child and parent by controlling intake and provide safe food source
Introduction of Solid Foods	Rice cereal and pureed solid foods (either commercial or homemade)	Homemade baby foods beginning with organic fruits and vegetables or commercially purchased organic food	Rice cereal and pureed solid foods (commercial)
Underlying Motivations for Feeding Decisions 4-6 to 12 months	Informed decision-making to adhere to expert advice, cultivate a positive attitude toward nutritious food, optimize health of child, and provide safe food source	Informed decision-making to provide natural, chemical/additive/pesticide free forms of nutrition; Experiment with flavors, spices, and variety of fruits and vegetables	Informed decision-making to optimize physical and mental health of child and parent by controlling intake and provide safe food source
Safety Determined By	Experts, scientific studies, cleanliness of environment/utensils	Organic certification, cleanliness of environment/utensils	Degree of control over quantity of food source, experts, scientific studies, cleanliness of environment/utensils

APPENDIX F

FORMULA FEEDING GUILT

	Exemplary Quotations	Characterization of Formula Feeding	Characterization of Good Mothering
Reassurances from Experts	<p>“Some women who choose the bottle instead of the breast are bothered by their decision. They worry they’re not being a good mother or putting the needs of their child first. If you’re among this group, don’t shower yourself in guilt” (Krych, Johnson, & Cook, 2012, p. 43).</p>	<p>Formula feeding is a choice.</p>	<p>Good mothers can either breastfeed or formula feed. Good mothers worry but do not become overwhelmed by guilt.</p>
	<p>“If you’ve chosen to use formula, don’t feel guilty. Know that you’re giving your baby a great start in life” (Kahn, 19 January 2012, para. 4).</p>	<p>Formula feeding is a nutritious choice and should not produce guilt.</p>	<p>Good mothers can be formula feeding mothers.</p>
	<p>Linked on a parenting.com blog post, Erin Ruddy’s <i>Redbook</i> article discusses how she just needed a little reassurance to quit breastfeeding. “This was my third bout of mastitis – a serious infection that I later learned was caused by MRSA, a potentially fatal strain of antibiotic resistant bacteria. I was at the end of my rope. That’s when the doctor uttered the five most magical words I’d heard since giving birth: ‘It’s okay not to breast-feed.’ Actually, she shouted them. “If it were 1907, your child would die if didn’t breast-feed!’ she shrieked. ‘But it’s 2007. We have choices,</p>	<p>Formula feeding is a good choice and may be the best choice for maternal and child health.</p>	<p>Good mothers are self-sacrificing, that is willing to give their bodies over to breastfeeding, but there are limits as to what is healthy and good for mothers. Good mothers need the reassurance of medical professionals that it is okay to cease breastfeeding.</p>

	people!” (Ruddy, 2013, paras. 1-2).		
Reassurances from Mothers	“Don’t let ANYONE judge you for making the right decision for yourself and your family. FF [formula feeding] does NOT make you a bad mother or a failure in any way” (Community.babycenter.com, 2013, para. 4).	Formula feeding is a choice that should not produce judgment by other characters or produce guilt within mother.	Good mothers can formula feed.
Voicing Maternal Guilt/Failure	“After my daughter, who’s six months old now, was hospitalized for dehydration, I still kept hearing, ‘Hang in there. Don’t cave in and give her a bottle,’” says Tracy LeGrand, a mother of two in Camden, North Carolina. “They made it seem like anyone who’s willing to stick out the rough times can do it. That attitude made me feel like a failure” (Stanley, 2000, p. 40).	Formula feeding is a last choice. Formula feeding is a choice that is constrained and may not feel like a choice.	Good mothering should not be defined by breastfeeding, but mothers will be pressured to continue breastfeeding and feel guilty if they cannot make breastfeeding work.
	“I knew it was irrational, but when I thought of nursing, I thought of pain, depression, frustration, craziness, and most of all, failure. My word associations with ‘formula’ were salvation, ease, freedom. Along with those positive association came others, too. Like selfish, lazy, unfair. Cheater. I felt tremendous guilt over these emotions” (Barston, 2013, p. 2, paras. 1-2).	Formula feeding represents conflicting emotions. Formula feeding is positively constructed as salvation, ease and freedom and negatively constructed as selfish, lazy, unfair, and cheating.	Good mothers wrestle with feeding choices and experiences. Although formula feeding is good, it also generates a sense of failure.
Voicing Maternal Perceptions of Judgment	“According to all of the medical literature, all the websites, all the popular social media, I had failed to feed my first child correctly. It didn’t matter that breast milk made	Formula feeding is a choice that is constrained and may not feel like a choice. Formula feeding	Good mothering should not be defined by breastfeeding in instructional texts, but mothers will

	<p>him sick; there was no way a human could be allergic to its mother's milk--I just hadn't cut out enough foods from my diet.... It didn't matter that I was drowning in depression and anxiety; breastfeeding should have improved my mood, and even if it didn't, I should have pushed through for my son's sake. It didn't matter that he thrived on formula; that was simply good luck, and of course, there was still time for the repercussions to develop. And most of all, it didn't matter that I felt with every bone of my body that formula was the right choice for our family. That made me selfish, ignorant, and irresponsible. It made me a bad mom" (Barston, 2013, p. 3 para. 2).</p>	<p>is condemned by experts and baby care texts. Formula feeding produces judgment by other characters.</p>	<p>be judged for how they feed their children.</p>
	<p>"Andrea Gideon dreads shopping for infant formula. 'Haven't you even tried breastfeeding?' cashiers have chided. And once while perusing the store, with formula in her basket and son nestled cozily in a sling, she encountered another mother whose baby was also in a sling—at the breast. The two made eye contact, but instead of returning Gideon's smile, the woman said, 'Don't you know you're feeding your baby artificial crap? It's going to make him sick'" (Stanley, 2000, p. 139).</p>	<p>Formula feeding is a choice that results in social judgment.</p>	<p>Good mothering should not be defined as breastfeeding, but mothers will be judged for how they feed their children. Formula feeding mothers are good mothers who are victimized by breastfeeding zealots.</p>

APPENDIX G

STRICT NATURALISM AND CHALLENGES TO BREASTFEEDING

Challenge Identified	Representative Quotation from Strict Naturalism Text
Expert to Turn to for Help	“One additional problem is that there’s some confusion about where these moms should turn for the help they need: ‘Doctors practicing today don’t know where to place breast-feeding problems – breasts are attached to the women, so shouldn’t they be the province of OBs, say pediatricians. And OBs note that breast-feeding is for infants; shouldn’t the baby’s doctor handle it?’” (Newman, 5 January 2013, para. 6).
Lack of Research and Language to Discuss Lactation Failure	“In fact, ‘Within the database of federally funded medical research, there are 70 studies on erectile dysfunction; there are 10 on lactation failure.’ Lactation dysfunction isn’t even ‘real’ in medical diagnosis parlance, so doctors attempting to address it come up against a wall when it comes to billing insurance companies for their time and any relevant testing” (Newman, 5 January 2013, para. 4).
Censoring and Demonizing Public Breastfeeding and Breastfeeding Imaginative Play	“Pretending to be a parent is a part of being a kid! And breastfeeding a baby is part of being a parent, for many parents, anyway. That children play at this is wonderful. They’re imitating a moment of nurturing and closeness that is perfectly natural and appropriate between parents and their little ones. Children who play at this will undoubtedly be far less affected by our culture’s conflicted relationship with breasts, and far more comfortable breastfeeding their own babies when they become parents themselves” (Newman, 14 November 2012, para. 4).
Sexualized Breast	“For new moms and midwives, breasts are a part of the new baby deal, and not the hyper-sexualized sell-anything objects normally aimed at the public male gaze” (Newman, 10 October 2012, para. 2). “They [breasts] sell things, sure, but they also feed babies. (Which trick do you think is cooler?)” (Newman, 9 May 2012, para. 5).
Hospital Policies and Practices like Rooming In and Formula Goody Bags	Covering a Mother-Baby Summit in Michigan, <i>Parenting</i> blogger, Taylor Newman writes about the summit and its aims to change hospital policies to encourage breastfeeding. “Allowing moms and babies to ‘room in’ together post-delivery, for example, has been shown to make a big difference in long-term breastfeeding success, as have the other nine steps outlined in the Baby-Friendly Hospital Initiative, which was outlined in the

	1990s by Unicef and the World Health Organization, but today, over a decade later, is still very much in need of widespread implementation in America’s hospitals” (Newman, 7 October 2012, para. 1).
Childcare and Breastfeeding in Public	Discussing the publicized breastfeeding professor who breastfed her sick child during the first day of class, Taylor Newman (18 September 2012) writes, “This particular controversy arose out of a misunderstanding that takes place nearly constantly between breastfeeding women and the public-at-large. But I agree with this writer [for the university newspaper] in asserting it’s also a real-world example of other issues we should all be thinking and talking about (and would be if they weren’t being totally overshadowed by our weird American brand of ambivalence around breasts): issues relating to working parents, and childcare options, for example” (para. 3).
Limited Parental Leave	“Breast-feeding exclusively for the first year is just not feasible for many women, who sometimes get six weeks of paid maternity leave but often get none” (Newman, 18 July 2012, para. 3).
Employer-Employee Pumping Policies/ Arrangements	Newman explains the legal obligations of companies to nursing moms, but even so, she had different experiences. “It [AAP report with section on the “Business Case for Breastfeeding”] references the Patient Protection and Affordable Care Act passed by Congress in March of 2010, which requires employers to provide “reasonable break time” for nursing mothers, and private, non-bathroom areas for pumping (I pumped in an in-office “phone booth,” one of two in three floors of company space, so there was often a line outside the door... and no lock), as well as resources business can utilize in setting up adequate nursing-mama spaces and systems” (2 March 2012, para. 4).
General Lack of Breastfeeding Support within Culture	“Breastfeeding works, but it can be hard in a culture that does not support it. If you have concerns, find mothers who have nursed their babies. As it has been for generations before us, the communal bond of mothers is essential” (Behan, 2008, p. 31).

APPENDIX H

CHARACTERIZATIONS OF EXPERTS ACROSS NUTRITIONAL NARRATIVES

	Type of Expert	Characterization of Expert	Exemplary Quotes
Moderate Naturalism	American Academy of Pediatrics (AAP)	AAP is the indisputable authority on health, safety, and nutrition as reflected in their policies, guidelines, publications, and membership.	Parenting.com invited the AAP to publish an article explaining their new breastfeeding policy. It begins, “The decision to breastfeed is not a lifestyle choice but rather a basic and critical health decision regarding infant welfare. In fact breastfeeding benefits extend into adulthood with lower rates of obesity, cardiovascular disease risk factors, diabetes and malignancies” (AAP, 2013, para. 1).
	Biomedical Research Studies	Research of the natural world, specifically human biology, produces evidence-based nutrition guidelines and conclusions.	“Breast milk also inhibits the growth of bacteria in the lungs, mouth, and nose. A 1998 study showed that infants solely breastfed for six months have shorter episodes of respiratory illness (pneumonia, runny nose) during that time” (Lathrop, 1999, p. 33). “A large German study published in 2009 found that breastfeeding – either exclusively or partially – is associated with a lower risk of sudden infant death syndrome (SIDS)” (Babycenter.com, 2012a).
	Pediatricians	Pediatricians comprise a professional group who translate AAP and biomedical research to parents in their clinical	“When your baby first latches on, you’re going to feel some pain – at least until you and your infant get the positioning right, typically after a few days, says Dr. DiSanto” (Lanigan, 2000, p. 1999).

		practices. Thus, pediatricians possess both educational and experiential competencies with pediatric nutrition.	To nurse a stuffy baby, “Try holding her in an upright position while you feed her. ‘Your baby may breathe more easily when she’s propped up,’ says Linda Black, M.D., a pediatrician in St. Louis Park, MN” (Nursing a stuffy baby, 2001, p. 33).
	Nurses and Lactation Consultants	Nurses and lactation consultants are positioned as having specialized breastfeeding knowledge and hands-on, technical know-how. Their expertise is highly valued during pregnancy and in the first 4-6 months postpartum.	“Colette M. Acker, certified lactation consultant and executive director at the Breastfeeding Resource Center in Abington, Pennsylvania, offers these tips for boosting your supply...” (Meitner, 2013, para. 1).
	La Leche League (LLL)	LLL’s scope of expertise is breastfeeding. This group is represented as a source of breastfeeding support advantageous to mothers seeking to implement AAP breastfeeding recommendations. LLL’s authority is derived from their alignment with the AAP and biomedical research.	“Call La Leche League at 877-452-5324” (Meitner, 2012, para. 3). “Your local La Leche League leader can also pair you with an experienced nursing buddy” (Meitner, 2012, para. 4). “If I had contacted La Leche League, an international organization of breastfeeding mothers, sooner, I could have avoided some basic nursing difficulties...” (Roth, 2013, p. 3, para. 10).
Synthetic Acceptance	American Academy of Pediatrics (AAP)	The AAP is the authority on pediatric nutrition. However, their guidelines, derived from policy statements and research, are not	“Notice the emphasis of the newer AAP statement – the advice given is to counsel the mother on the benefits of breastfeeding <i>first</i> , and <i>then</i> inform her of the potential risks and unknowns of nursing on on

		indisputable.	her medication. Anyone with a grade-school understanding of psychology can figure out what that would sound like. (‘Breastfeeding is extremely important and will save your child from every ill imaginable! But I should warn you that if you choose to nurse while on Zoloft, we can’t confirm or deny that you baby may turn into a werewolf when he reaches puberty. Your choice!’” (Barston, 28 August 2013, para. 7).
	Biomedical Research Studies	Research of the natural world, specifically human biology, produces evidence-based conclusions about pediatric nutrition. However, reporting of this data may be misleading, and studies that contradict widely circulated breastfeeding advantages do not receive attention.	“Most importantly, don’t believe everything that you hear or read because the next week, there will be another study that refutes the one you just read or heard about” (Kahn, 29 October 2012, para. 4).
	Medical Practitioners	Pediatricians, nurses, lactation consultants, and other medical practitioners have specialized pediatric nutrition knowledge. These practitioners are not objective in their pediatric nutrition instruction and contribute to maternal guilt if mother does not breastfeed according	“This was my third bout of mastitis – a serious infection that I later learned was caused by MRSA, a potentially fatal strain of antibiotic resistant bacteria. I was at the end of my rope. That’s when the doctor [OBGYN] uttered the five most magical words I’d heard since giving birth: ‘It’s okay not to breast-feed.’ Actually, she shouted them. “If it were 1907, your child would die if didn’t breast-feed!’ she shrieked. ‘But

		to AAP recommendations. However, these practitioners can be very influential in overcoming guilt.	it's 2007. We have choices, people!" (Ruddy, 2013, paras. 1-2).
	Formula Feeding Mothers	Formula feeding mothers legitimize one another's experiences and provide social support for one another.	"Don't let ANYONE judge you for making the right decision for yourself and your family. FF [formula feeding] does NOT make you a bad mother or a failure in any way" (Community.babycenter.com, 2013, para. 4). "I simply cannot fathom why I'm supposed to feel guilty about" formula feeding (Fearlessformulafeeder.com, 27 April 2013, para. 20).
Strict Naturalism	Medical Doctors (MD's) and the American Academy of Pediatrics (AAP)	MD's and the AAP's authority fluctuates in terms of the consistency of their recommendations with natural feeding practices. AAP recommendations related to breastfeeding are consistent with natural feeding methods; however, their dismissal of organics gives rise to questioning of their authority. MD's are criticized for over-medicating and lacking sensitivity to holistic and alternative medicine.	"We hacked it through a difficult first year of full-body baby eczema and very little sleep, which proved to be a mystery to our MD's, but culminated in a visit to the ER when Kaspar went into allergic shock after chowing on some (organic) lentils" (Newman, 23 January 2012, para. 5).
	Environmental Research and Certification	Knowledge of the natural world is the impetus for organic	"And a July 2007 study conducted by researchers at the Public Health Institute, the

		feeding choices and provides credibility for environmental activism.	California Department of Health Services, and the UC Berkeley School of Public Health “found a six-fold increase in risk factor for autism spectrum disorders (ASD) for children of women who were exposed to organochlorine pesticides” (Newman, 12 September 2012, para. 5). “To carry the official “organic” label in the United States, food must be grown according to a set of uniform standards approved by the U.S. Department of Agriculture (USDA)” (Knight & Ruggiero, 2010, p. 13).
	Natural Parenting Network	This network of parents, who self identify as natural, is a trusted resource for feeding information consistent with strict naturalism.	“Families research and consider the benefits of eating local, organic, and/or healthy foods (no artificial colors, etc.)” (Naturalparentsnetwork.com, 2013, para. 15).
	“Crunchy” Parents	“Crunchy” parent blogs are commonly referenced and link to one another, and these parents’ stories and advice is commonly cited. References to one another reflect identification with one another and differentiation with other nutrition narratives.	I think a lot of us are leaning more and more toward ‘natural’ parenting because, well, it feels right to us (“natural,” if you will). I’ve cared deeply about my son’s well-being from the get-go, but it’s only since his birth that I’ve <i>really</i> cared about the planet – socially, environmentally – he, and the rest of his generation, will inherit” (Newmann, 23 January 2012, emphasis in original, para. 6).