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Bearing Class: Citizenship, Status, and the Maternal Body

by

Katherine Abigail Mason

A dissertation submitted in partial satisfaction of the

requirements for the degree of

Doctor of Philosophy

in

Sociology

and the Designated Emphasis

in

Women, Gender, and Sexuality

in the

Graduate Division

of the

University of California, Berkeley

Committee in charge:

Professor Raka Ray, Chair

Professor Sandra Smith

Professor Charis Thompson

Fall 2012

Abstract

Bearing Class: Citizenship, Status, and the Maternal Body

By

Katherine Abigail Mason

Doctor of Philosophy in Sociology

Designated Emphasis in Women, Gender, and Sexuality

University of California, Berkeley

Professor Raka Ray, Chair

This dissertation compares the health-enhancing projects of lower- and middle-class U.S. women during pregnancy and postpartum. Current social stratification scholarship pays scant attention to the role of the body, while the literature on reproductive labor—which shows bodily carework to be a highly gendered activity—often disregards class. In my dissertation, I argue that the maternal body serves as a key site of class inequality at both structural and individual levels, simultaneously reflecting class differences and reproducing them through the techniques mothers adopt to cultivate their own health and their children's. Such projects (especially changes in diet and exercise) are common in mothers across racial/ethnic, socioeconomic, and geographic locations, even as their contents vary. Yet, while women's bodily practices may affect their physical wellbeing, such habits also are saddled with a range of social and moral meanings that are reinforced through the institutions in which mothers participate. Revealing the lie in oversimplified rhetorics of “good” versus “bad” mothers, my research shows how class mediates the near-universal efforts of new mothers to maximize their own health and their children's.

Based on interviews and ethnographic observations I conducted with middle-class mothers and in offices of the federal Women, Infants, and Children (WIC) program in California and Florida, I present four main findings. First, WIC, a federal program for low-income women, aims to supplant traditional knowledge about the maternal body with medical authority. It also works to induct participants into what I call “neoliberal citizenship,” emphasizing self-control and decreased reliance on public health services. Second, informal institutions popular among middle-class mothers—“mommy groups” and online message boards—offer members support and information, but also a space in which to assert mastery over body care habits and to engage in status contests with other mothers. Third, I suggest that differences in material, cultural, and institutional circumstances lead mothers to adopt divergent forms of agency with regard to the care of their bodies; while both groups in my study seek to make the right choices for their children's health and development, poor and working-class mothers' constrained choices tend to be misrecognized as lacking agency. Fourth, while recent research has fixated on mothers' self-care habits during pregnancy as determinants of children's physiological and developmental outcomes, I suggest that the modes through which they cultivate their children's bodies serve to transmit class-specific bodily knowledge and ethics, constituting children as classed subjects and reproducing both privilege and disadvantage across generations.

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In time, Charis Thompson and Sandra Smith joined my dissertation committee, each bringing her own critical remove from the project and, as a result, driving me to make my arguments legible to a broader scholarly audience. On the front end of the project, Sandra kept me mindful of the social and cultural distances that often separated me from my interview subjects. She urged me to develop interview questions that were sensitive to those distances and that respected the initial reservations some mothers might have about discussing intimate bodily experiences with a young, childless graduate student. During the writing and analysis phase of this project, Charis held me accountable to the nuances of my findings, challenging me to look for articulations of race and class and to note not just what my interviewees said, but how they said it.

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Virtually every dissertation owes its completion to the care and creative engagement of the writer's family, friends, and advisors. Yet I suspect—quite un-sociologically—that my experience was unique in this regard. Throughout the process of conceptualizing, researching, and writing this dissertation, I belonged to a writing group organized and led by our mutual chair, Raka Ray. Abigail Andrews, Kemi Balogun, Jenny Carlson, Dawn Dow, Katie Hasson, Kimberly Hoang, Kate Maich, Jordanna Matlon, Sarah Anne Minkin, and Nazanin Shahrokni gave generously and untiringly in their feedback, reading and commenting on multiple drafts of several chapters contained herein. Despite the breadth of topics in the group, including projects ranging from motherhood to conservative gun politics, Vietnamese sex work, and Nigerian beauty pageants (to name just a few), every group member demonstrated a strong feminist commitment to collaborative work and a genuine curiosity about the projects of others. Dissertation writing can be an isolating experience, but as a part of this group, I never once felt that I was doing it alone.

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CHAPTER ONE

Introduction: Self-Help and the Classed Body

The government of the soul depends upon our recognition of ourselves as ideally and potentially certain sorts of person, the unease generated by a normative judgement of what we are and could become, and the incitement offered to overcome this discrepancy by following the advice of experts in the management of self. The irony is that we believe, in making our subjectivity the principle of our personal lives...that we are, freely, choosing our freedom. (Rose 1990: 10-11)

We are living, in the contemporary United States, in a self-help society. The massive commercial success of self-help queen Oprah Winfrey and several of her protégés—Rachael Ray, Dr. Oz, and Dr. Phil—speaks to the predominance of the self-help paradigm, and the ways in which we have turned to experts to guide us in taking care of ourselves. Furthermore, while previous scholarship on this self-help society has often focused on psychology and the mind, one of the most frequent targets for self-improvement is the body. Winfrey repeatedly documented her struggles to lose weight on her eponymous talk show, publicly agonizing over “what [she was] and could become” (Rose 1990: 11). Indeed, one of her long-time contributors was Dr. Mehmet Oz, a cardiothoracic surgeon she enlisted to come and speak about biomedical interventions for health, weight loss, and anti-aging beauty treatment, and who, today, frequently promotes diet and weight loss products on his own website and talk show.

On one hand, the success of these self-help gurus is a reflection of their populism: Winfrey, a self-made billionaire, connected with her middle-American viewers by speaking to them as friends and equals; Winfrey’s protégés, too, cultivated television personas marked by chumminess and familiarity. On the other hand, the success of the self-help genre has been, I argue, the product of necessity. In the closing decades of the twentieth century, American public policy began to back out of its commitments to care for its citizens. Welfare reforms limited the amount of help mothers could expect from the government while raising children, health care and education were increasingly outsourced to the private sector, and the expansion of market-based morality into non-economic spheres of life more generally—known as *neoliberalism*—institutionalized a doctrine of radical personal responsibility. Within this political and economic climate, one might ask, “If I don’t help myself, who will?”

Yet, if the state seemed to withdraw from its traditional responsibilities toward its citizens, it nevertheless maintained an interest in those citizens’ self-help endeavors. It has done so through what Nikolas Rose (1990) calls the “government of subjectivity,” in which “authorities act upon the choices, wishes, values, and conduct of the individual in an indirect manner” (p. 10). As individuals, we are offered choices about how to live our lives, and commercial products and techniques with which to “act upon our bodies, souls, thoughts, and conduct in order to achieve happiness” (p. 10). The state and capital benefit from these self-help projects to the extent that they can be linked to “political values of consumption, profitability, efficiency, and social order” (p. 10). Consumer culture offers us a bridge between who we are and whom we wish to become, and promises to help us cross that bridge—for a price. That price, as it turns out, becomes the basis for how access to social norms is classed. For, if consumption and profitability are the criteria on which “good” subjects are judged, middle- and upper-class individuals will continue

to enjoy privileged access to normative self-identity, thereby appearing not only luckier than their lower-class counterparts, but also *better*.

In this dissertation, I examine the bodily self-care and cultivation habits of a group that has historically been targeted by self-help discourses: mothers. Throughout the bodily changes of pregnancy, childbirth, and the postpartum period—what I term, collectively, *maternal embodiment*—women are subjected to an unprecedented amount of coaching, well-meant (and not-so-well-meant) advice from loved ones and strangers alike, and instruction from commercial and governmental publications all promising to teach women how to care for bodies and to maximize their children’s chances for health, optimal development, and professional success in later life. With a particular focus on strategies of, and attitudes toward, self-care, I argue that the care and cultivation of the body has become a central means through which social status is asserted, maintained, and—to one’s children—transmitted.

Why Bodies?

In one sense, social status has contained a strong bodily component for as long as sociologists have studied it. Institutionalized discourses of racism and sexism often take recourse to the body and bodily differences as a means of explaining the so-called “natural” social order and legitimating one group’s dominance over another (Agamben [1995]1998; Bordo [1993]2003; Epstein 2004; Fausto-Sterling [1985]1992; Lorber 1993; St. Louis 2003; Young 2005). With regard to race and sex, in particular, various groups also tend to be associated with specific phenotypic characteristics that make most individuals readily identifiable in public spaces, thereby making it easier for strangers to “place” them at a glance and to determine how that person should be treated (Halberstam 1998; West and Zimmerman 1987). Secondary sex characteristics, skin tone, and hair texture (to name just a few) become socially relevant aspects of self-presentation insofar as they signal one’s membership in a group thought to be *biologically* distinct; in the contemporary U.S., other arbitrary physical characteristics like left- or right-handedness carry no such social significance.

Of course, not all of the social categories into which we divide people are so easily tied to physical characteristics, nor are snap phenotypic judgments about even race and sex always correct. In spite of these limitations, however, the body remains a key site for studying social norms and inequalities. In contrast to essentialist perspectives that take surface differences in bodies as evidence of natural, unalterable differences between individuals (and of the correctness of social segregation and inequality), in this project I examine bodily differences as they *reflect* and *reinscribe* social inequality. In taking this approach, I follow the work of feminist biologist Anne Fausto-Sterling (2005), who asks “what it might mean to claim that our bodies physically imbibe culture. How does experience shape the very bones that support us?” (p. 1495). Specifically, I ask how culture—social inequality, in particular—becomes embodied, looking at the class-conditioned ways we nourish our bodies, cultivate them through our choices about physical activity, substance use (and abuse), and medical care, and, ultimately, pass on embodied advantages and disadvantages to our children through the care we take of their bodies *in utero* and in early childhood.

At the same time, while Fausto-Sterling’s argument suggests that culture has always shaped the body—indeed, she cites the use of archaeological bone excavations to make claims about prehistoric human cultures—there is reason to suspect that class cultural differences in the body and its care carry particular significance in the contemporary U.S. In the 1970s, French sociologist Pierre Bourdieu wrote his landmark book, *Distinction*, about the ways that class

differences translate into differentiated tastes in culture, ranging from preferences in artwork and music to dietary and exercise habits. Although Bourdieu heeded the role of material and socioeconomic factors in shaping class tastes (such as the practical working-class ideal of a muscular male body suited for manual labor, as opposed to the more slender bourgeois male body that signaled leisure), a good number of these tastes appear rather arbitrary, tied less to their practical utility for the life circumstances of working-class or bourgeois individuals than to their ability to signal class difference. On one hand, Bourdieu's work is clearly influenced by the strong working-class identity that existed in France at the time he wrote; at several points, he portrays workers as being just as disdainful of bourgeois cultural preferences as the bourgeoisie are of workers'. On the other hand, Bourdieu begins to theorize how bodily differences across classes come to be understood as not just different, but *better* and *worse* (and, thus, as a way of legitimating social inequalities). He does so by introducing the concept of "class bodies," writing, "Taste, a class culture turned into nature, that is, *embodied*, helps to shape the class body" ([1977]1984: 190). When Bourdieu describes how culture is "turned into nature," he is not using "nature" to indicate something inevitable and unchangeable. Rather, in much the same way as Fausto-Sterling describes the body as "imbibing" culture, Bourdieu is arguing that seemingly involuntary personal preferences, habits, and proclivities are, in fact, the result of early and continuous exposure to class cultural norms about the correct manner of using and caring for the body. These norms become part of a class *habitus*¹ and, while cultural, take on the appearance of being innate, natural. Bourdieu goes on to chart some of the implications of this notion:

It follows that the body is the most indisputable materialization of class taste, which it manifests in several ways. It does this first in the seemingly most natural features of the body, the dimensions (volume, height, weight) and shapes (round or square, stiff or supple, straight or curved) of its visible forms, which express in countless ways a whole relation to the body, i.e., a way of treating it, caring for it, feeding it, maintaining it, which reveals the deepest dispositions of the habitus (p. 190).

Bourdieu's examples of working-class distaste for bourgeois bodily shapes and appetites notwithstanding, the body's ability to show one's ways of "treating it, caring for it, feeding it, [and] maintaining it" becomes the basis on which bodily differences may be used to justify class inequalities. Thus, "the legitimate use of the body is spontaneously perceived as an index of moral uprightness, so that its opposite, a 'natural' body, is seen as an index of *laissez-aller* ('letting oneself go'), a culpable surrender to facility" (pp. 192-3). In this schema, working-class people are more likely to be judged as "letting themselves go," as having bodies that are closer to nature and/or out of their personal control—the same criteria that are often deployed to denigrate the bodily habits of women, non-Whites, and children—while bourgeois subjects are credited with having bodies that are carefully cultured, cultivated, and controlled.

¹ Pierre Bourdieu ([1977]1984) describes *habitus* as "the internalized form of class condition and of the conditionings it entails" (p. 101). Bourdieu sees class as consisting of both financial position (economic capital) and cultural knowledge and education (cultural capital), and notes that the lifestyle to which one has become habituated—the habitus—may reflect something more about class membership than we could learn simply from knowing a person's position in the relations of production. Looking at the membership of certain professions, for example, he suggests that "the requiring of a given diploma can be a way of demanding a particular social origin;" it is no coincidence that these professionals "always have something else in common beyond the characteristics explicitly demanded" by their job (p. 102).

Bourdieu's theoretical exploration of class bodies occupies the space of a few short pages out of a book that numbers more than 600 pages. And yet, I argue that, in the contemporary United States, questions regarding the so-called "legitimate use of the body" have taken on critical importance within popular and scholarly debates, putting the body at the center of discussions about social inequality in a way Bourdieu never anticipated. Toward the end of the twentieth century, sociologists and political scientists began to develop a theory of large-scale domestic and transnational market trends that they called *neoliberalism* (Harvey 2005; Rose 1990; Treanor 2005). A number of countries, these scholars observed, had begun applying capitalist economic policies that extended classical liberal ideologies about free markets, yet did so radically, in a way that made market logic the primary basis for policy both at home and abroad. In this respect, neoliberalism represented a significant break with previous eras of capitalist policy and activity. At the macro level, neoliberalism is generally understood to promote free market activity by deregulating business while cutting socially redistributive programs like welfare. Yet, neoliberalism is marked not only by its intensification of liberal market ideology in economic policy, but also by its contention that the same ideology should be used to guide and judge individual action at the micro level. Extending market logics into non-economic spheres of personal life, neoliberal ideology values rational, self-maximizing behavior.

In particular, then, the care of the self is positioned as a moral virtue, with the body providing testimony for social judgments about individual morality and worth. Michel Foucault explains how neoliberal market logics permeate individual life, writing that the central citizen-subject for the neoliberal era is "an entrepreneur of himself...being for himself his own capital, being for himself his own producer, being for himself the source of his earnings" (1982: 226). To develop one's productive (and, thus, earning) capacity requires developing one's human capital, not only through education and training, but also through the cultivation of the body. Under this rationale, Foucault argues, "all the problems of health care and public hygiene must, or at any rate, can be rethought as elements which may or may not improve human capital" ([2004]2008: 230).

Wendy Brown (2005) further highlights the ways in which this entrepreneurial self of neoliberalism is bound up with values of self-control and personal responsibility:

Individuals [are seen] as rational, calculating creatures whose moral autonomy is measured by their capacity for 'self-care'—the ability to provide for their own needs and service their own ambitions...in so doing, [neoliberalism] carries responsibility for the self to new heights: the rationally calculating individual bears full responsibility for the consequences of his or her action no matter how severe the constraints on this action—for example, lack of skills, education, and child care in a period of high unemployment and limited welfare benefits. (p. 42)

Neoliberalism, Brown writes, entails the extension of rational, cost-benefit calculations from the marketplace into heretofore noneconomic realms of life; indeed, self-care and bodily management are now moral requisites of the neoliberal citizen. This idealized citizen-subject—the *entrepreneurial subject*—is "one who strategizes for her- or himself among various social, political, and economic options, not one who strives with others to alter or organize these options" (p. 43). Accordingly, neoliberal ideology minimizes or discounts the roles of bad luck or structural inequality in the life circumstances of individuals.

Many of these concepts—individuality, autonomy, and responsibility, for example—tend to sound somewhat abstract, even disembodied. However, they become the baseline values for judging the moral worth and worthiness of neoliberal subjects, and they are particularly salient for understanding the development of attitudes toward health and the body in the contemporary period. In this era, Nikolas Rose (2007) explains, “different ideas about the biological responsibilities of the citizen are embodied in contemporary norms of health and practices of health education” (p. 133). Although Rose is talking about something he calls “biological citizenship,” the norms he cites are incredibly similar to those Brown describes as being central tenets of neoliberalism. Specifically, he suggests that the biological is one component of a larger “regime of the self,” which is undertaken by “a prudent yet enterprising individual, actively shaping his or her life course through acts of choice” (p. 134). Thus, the care of the body becomes part of the grounds for full subjecthood and citizenship in the contemporary United States.

Why Mothers?

If neoliberal ideology is so pervasive as these authors claim, then it stands to reason that one might study just about any social group in order to understand its workings. Indeed, I suspect that there is much to gain from studying neoliberalism and the body among white-collar executives and among sub-minimum-wage service workers, by talking to women and men, adults and children, and people of wide-ranging colors, nationalities, and sexualities (to name just a few). However, for the current project I chose to focus on mothers.²

By using mothers for my case study, I positioned my project within an area (sociological and feminist studies of women and motherhood) that has, to some extent, reached a high degree of empirical saturation. On one hand, the choice to focus on mothers was methodologically motivated, but somewhat arbitrary: although this project is qualitative in nature, quantitative lessons about quasi-experimental study design prompted me to “control” for several shared characteristics in my study population (in this case, women who were biological mothers who were pregnant or who had at least one child under the age of 5 years) to enable a clearer understanding of the effects of my primary “variable”: class (and, to a lesser extent, race/ethnicity and geography). Although, as a non-random, qualitative project my results are by no means generalizable or representative in the statistical sense, this design choice enables me to make logical claims about the role of class in shaping my subjects’ day-to-day experiences of neoliberal embodiment.

On the other hand, the decision to use mothers as my study population is part of a theoretically informed strategy. As neoliberal subjects, women across classes are likely to have been exposed to the notion that their bodies are their own possession and their own responsibility. At the same time, the maternal body—defined, in this project, as being pregnant, breastfeeding, or up to five years postpartum—is unique in its direct, physical connection to the life and wellbeing of another. As such, mothers are subject to increased scrutiny over their self-care choices (weakening the claim that their bodies belong to them alone) while facing doubled responsibility—for their own health, but also for that of their child. In a series of essays on gender and embodiment, philosopher Iris Marion Young writes about her own experiences of

² Here and throughout the rest of this work, I will use the term “mother” as shorthand for women who have conceived, borne, and raised a child (or who are in the process of doing so). My point here is not to invalidate other women who mother; rather, I seek to highlight the shared physiological experiences of the women in my study.

pregnancy, childbirth, and breastfeeding to claim that this period—which I term, collectively, *maternal embodiment*—is qualitatively distinct from other phases of women’s lives. During this time, the porous boundaries between the mother’s body and that of her child become blurred, thereby issuing a radical challenge to classical liberal notions of the discrete, independent subject. As a result, Young writes, “the pregnant subject...is decentered, split, or doubled” (p. 160). Young explains that she experienced a rare feeling of social approval for her body during pregnancy due, she argues, to the fact that motherhood is one of the few life paths for women that is met with widespread positive reception.

Young’s personal story of a reprieve from social judgment during pregnancy notwithstanding, a substantial body of evidence suggests that social approval for women during the maternal embodiment period is, at best, unstable and conditional. In 2009 and 2010 (the year in which I collected my data), American lawmakers fiercely debated—and nearly defeated—an omnibus healthcare reform bill, the Patient Protection and Affordable Care Act (PPACA), over concerns about insurance coverage of induced abortion (Cohen 2010). Supporters of the bill argued that it would not seek to override the existing Hyde Amendment, which forbade the use of certain federal funds to pay for abortion (a procedure that, at the time of these debates, was legal in the U.S.). Nevertheless, several members of the U.S. House of Representatives, led by pro-life Democratic Congressman Bart Stupak, refused to vote in favor of the PPACA until the provisions of the Hyde Amendment were specifically reiterated within the new bill. Regardless of one’s personal politics regarding legalized abortion, one thing this debate makes plain is that pregnant women are hardly subject to universal approval for their choices regarding their bodies.

Public discourses about women’s bodies and fertility draw on not only religious and moral beliefs, but also scientific study. Rosalind Pollack Petchesky (1987), for example, describes the use of fetal ultrasound imaging—designed to aid in monitoring maternal and fetal health throughout the pregnancy—in political fights over abortion. Prenatal ultrasounds reinforce pregnant women’s dependent position vis-à-vis science; such technologies contend to know women’s bodies better than the women themselves, and they hold the power to reveal previously hidden “truths” about the body (such as fetal deformity, sex, and—from the perspective of anti-abortionists—proof of personhood). Petchesky argues that sonogram technology facilitates a “panoptics of the womb,” in which “the woman’s *felt* evidence about the pregnancy is discredited, in favor of the more ‘objective’ data on the video screen” (p. 277). As these images—often depicting the fetus as a free-floating “spaceman” and “effacing the pregnant woman and the fetus’s dependence on her” (p. 270)—spread, they enable not only doctors but also the general public to feel they know what is best for the pregnant woman and her fetus, over and, often, against the judgment of the woman whose body is in question.

Public and scientific scrutiny of women’s reproductive choices may begin at their decisions about whether to become—or stay—pregnant, but it does not end there. As medical technologies and scientific knowledge are sometimes invoked as a way of forcing pregnant women to become mothers, they have also been used as rationales for preventing other women from having children. In the early twentieth century, theories of genetics, heredity, and the biological contributions to intelligence and “fitness” were brought together under the auspices of eugenics. This movement sought to encourage childbearing among the genetically “fit” while engaging in the “coercive enforcement of *negative* eugenics, which aimed to prevent socially undesirable people from procreating” (Roberts 1999: 65). By the 1920s, 30 states had laws permitting the involuntary sterilization of those deemed unfit to reproduce: criminals, the mentally ill, epileptics, the “feebleminded,” and, in particular, young women judged to exhibit

sexual immorality. Furthermore, “because most statutes mandated sterilization only for people confined to state institutions, they were imposed primarily against the poor,” especially poor people of color (p. 67).

More recently, the U.S. state has sought to limit poor and non-White childbearing through welfare policy. The neoliberal 1996 welfare reforms (discussed in more detail in the next chapter) included, among other changes, a “cap” on children’s benefits. This cap was not set at a particular number; rather, any child conceived while its mother was on welfare would be ineligible for welfare benefits, and the mother would receive no exemption from welfare’s work requirements to give birth or care for the new baby (Hays 2003). This policy change has been, in effect, an economic sanction aimed at controlling poor women’s sexuality. Even more directly affecting poor women’s fertility have been the state-sponsored initiatives to “pressure women on welfare to use [Norplant, an implantable hormonal contraceptive] either by offering them a financial bonus or by requiring implantation as a condition of receiving benefits” (Roberts 1999: 109). As Dorothy Roberts (1999) argues, such policies are overtly classed, and may also be a way of covertly targeting the fertility of women of color: “Because class distinctions are racialized, race and class are inextricably linked in the development of welfare policy. When Americans debate welfare reform, most have single Black mothers in mind” (p. 110).

Following childbirth, women’s decisions regarding their own bodies and their children’s continue to face intense social scrutiny. The doctrine of *scientific motherhood* (Apple 1987; 1995), which arose around the turn of the twentieth century in the United States, sought to replace maternal “instincts” with scientific rigor in the care and feeding of children. Thus, “truly scientific motherhood...required that mothers not merely study their children but read and follow the advice of scientifically trained experts” (Strasser [1982]2000: 232). Such experts insisted that “regular habits of eating and sleeping should begin at birth; the experts provided schedules, telling mothers both what should happen at any given time of a given day and how those schedules should change as the child grew older” (Ibid.: 232). In this way, the advent of modern motherhood and childrearing reflects the same sorts of dynamics highlighted by Michel Foucault in his studies of modern disciplinary techniques: an area of human life or behavior is brought under the authority of scientific expertise, subjected to regimentation through timetables, and, thereby, disciplined and trained. In considering the effects of such subjection to scientific knowledge, Foucault argues that “power produces knowledge...; that power and knowledge directly imply one another; that there is no power relation without the correlative constitution of a field of knowledge, nor any knowledge that does not presuppose and constitute at the same time power relations” ([1975]1995: 27). Even though the disciplining of infant sleep and feeding schedules at first seems to focus on the bodies of children, the result has been that mothers, who have been largely held responsible for administering these schedules, experience that discipline simultaneously.

One particular arena that involves both maternal bodies and the strictures of scientific motherhood is that of breastfeeding and the rise of synthetic infant formula. Rima Apple (1987) explains how, in the first half of the twentieth century, the ideology of scientific motherhood asserted that “[g]iving birth made a woman a mother in the physical, biological sense only; a good mother had to learn about mothering from authoritative sources” (p. 114). Infant formula, which was first developed as a supplement for insufficient milk production, gradually came to be marketed as the more “scientific” way to feed one’s child. Most doctors continued to believe that “breast is best”, but in-hospital feeding schedules for newborns often favored the predictability and ease of bottle-feeding when compared to breastfeeding, which required greater involvement

of (and attention to) the individual maternal body (p. 127). Similarly, contemporary techniques originally designed to treat emergency birth situations—Caesarian sections and artificially induced labor—have been scrutinized in recent years for their propensity to be used in accordance with physician convenience or standard timetables of labor progression, not indicated medical need (Grobman 2007; Murthy et al. 2008; Simpson 2007).

Thus, mothers' embodiment carries with it a long history of particular social scrutiny. Yet, while such scrutiny may not be new in itself, this project will seek to show how the experience of maternal embodiment is—or is not—altered in the context of early twenty-first-century neoliberalism.

Neoliberalism, Biomedicine, and the Question of Class

Neoliberal ideology has ushered in an era in which great social significance is attached to the care and use of the body. As scholars like Wendy Brown and Nikolas Rose explain, this development emphasizes an unprecedented degree of individual responsibility in cultivating the body. Yet those with sufficient financial means are not wholly alone in navigating their bodily responsibilities: along with neoliberalism, there has been a corresponding expansion in the medical field to meet (and, some would argue, construct) consumers' increased demands. This expansion is known as *biomedicalization*.

The key feature of biomedicalization is its extension of medical authority to areas of life previously thought to be “moral, social, or legal problems” (Clarke et al. 2010: 1), similar to how neoliberalism has extended economic logic beyond the sphere of productive work. To this end, biomedicalization involves a focus on optimizing health and the body in addition to treating illness, with an eye toward increasing “control [of] the vital processes of the body and mind” (Rose 2007:16). Some examples of biomedical technologies and treatments include genetic screening for disease risk (Clarke 2010), prophylactic mastectomies among women with a family history of breast cancer (Fosket 2010), and bariatric “weight-loss” surgery (Boero 2010). Such treatments tend to focus not on present health and illness, but on the risks of future ills one may face. The types of self-cultivation demanded of pregnant women in the contemporary U.S. also fall into this category, as women routinely undergo prenatal screening to determine the fetus' risks of birth defects and modify their diets not only to avoid harm, but also to enhance the health and brain development of their offspring. Laura Mamo's (2010) work on biomedicine and commodified sperm donation shows how consumerism allows for an expanded definition of risk (and the acceptable choices for dealing with such risk): sperm bank customers “are encouraged to enhance the next generation by reducing not only the risk of potential illnesses but also the risk of perceived cultural liabilities...In other words, these users are presumably averting not only disease risk but also the risks of social mediocrity” (p. 184). For those with the means to pay, says Mamo, infertility thus “transforms from a problem to an opportunity” to create a genetically optimized child (p. 184). More broadly speaking, even parents who conceive their children without the aid of reproductive technologies have at their disposal a breathtaking range of techniques with which to promote their children's health and development outcomes (a topic to which I will return in the final chapter).

Another parallel between neoliberalism and biomedicine is in their uneasy relationship to traditional authority (the state and the medical establishment) and their concurrent valorization of individual rights and responsibilities. As Nikolas Rose (2007) recounts, the second half of the twentieth century brought with it a number of challenges to medical authority. Patients' rights groups, feminist health organizations, and AIDS activists, to name a few, bristled against the all-

too-human prejudices and oversights of physicians, and worked to “‘empower’ the recipients of medical care...[via] ‘active citizenship,’ the rise of cultures of litigation and compensation, the transformation of patients into ‘consumers,’ and the growing availability of medical information on the Internet” (Rose 2007: 10). This movement demanded greater accountability from the medical establishment, but its effects, both intended and unintended, have proven to be a double-edged sword. If individual patients are consumers, able to buy their way into medical trials or to insist upon the pursuit of certain lines of disease research (Best Forthcoming), then it follows that not all patients will have equal access to these promising new techniques for optimizing the body.

Therefore, even though neoliberal ideology holds all people accountable for the correct care and cultivation of their bodies, access to biomedical solutions is not equally available to all. As Clarke and colleagues (2003) write, the effects of the biomedicalizing trend are heavily stratified:

Even as technoscientific interventions extend their reach into ever more spaces, many people are completely bypassed, others impacted unevenly, and while some protest excessive biomedical intervention into their lives, others lack basic care.
(p. 170)

Thus, the rapid expansion of medical authority, known sometimes as “cooptative medicalization” (Ehrenreich and Ehrenreich 1978, c.f. Clarke et al. 2003), accompanies a second dynamic in biomedicine: “exclusionary disciplining.” The latter “refers to the *simultaneous* exclusionary actions of medicine that erect barriers to access to medical institutions and resources that target and affect particular individuals and segments of populations” (p. 170). Together, the dynamics of cooptative medicalization and exclusionary discipline go a long way toward explaining the particularly stratified workings of biomedicine: more and more areas of life have been marked by the presence of risk (and the need for biomedical intervention), but the solutions for diagnosing and minimizing such risk are limited to those with the financial and/or social resources with which to consume them.

THE STRATIFIED CONSEQUENCES OF NEOLIBERALISM

	State policy	(Bio)medicine
General trend	Promotion of free market activity, individual self-development, and personal responsibility	Expansion of medical authority and intervention into new areas of life, expanded notion of “risk”
How it manifests for:		
<i>Middle and Upper Classes</i>	Withdrawal of state oversight from daily life, support for expanded consumer choice on the market and for “enterprising subjects”	Greater sense of risk, wider range of choices for care and preventative assessment (and treatment) of that risk. New investment in high-cost therapies.
<i>Poor and Working Classes</i>	Defunding of entitlement programs; shift in remaining aid programs (“workfare,” WIC) toward subjectification (crafting self-sufficient, neoliberal subjects)	Disinvestment in low-profit therapies and preventative care; poor thus less able to afford both basic care and long-range biomedical risk assessments

Thus, some women—generally those with a degree of educational, racial/ethnic, or class privilege—will be more likely to receive biomedical assistance in optimizing their bodies and health, while those on the margins may have less experience with cultivating their bodies in this way and/or lack the resources to do so. This disparity originates *not* in differing degrees of knowledge or long-term planning across classes, but in differential access to health insurance, disposable income, and secure jobs with flexible hours. In the final empirical chapter of this project, I will ask not only how mothers’ class position and resources affect their ability to optimize their bodies and those of their children, but also how biomedical strategies for cultivating children’s health, intellect, development, and even self-care values may form a pathway for status transmission from one generation to the next.

Methods and Subjects

My central focus in this project was to understand both the structural contexts within which middle- and lower-class U.S. women learn about norms for self-care during the maternal embodiment period and the individual-level meanings they attach to their experiences thereof, thereby allowing me to capture both the top-down and the bottom-up processes through which maternal body care reflects and reproduces social inequality. Accordingly, I selected a mixture of qualitative methods aimed at capturing these different levels of meaning.

Sites

At the time I began this project, I was living in California’s San Francisco Bay Area, with several years’ exposure to the region’s middle-class culture of “natural” health, diet, and exercise practices already under my belt. Although it would remain to be seen whether these practices filtered into poor and working-class attitudes toward body care, and whether they influenced maternal embodiment in particular, I suspected that they might be outliers relative to maternal embodiment habits in other parts of the country. For this reason, I decided to add a second research site, ultimately settling on a region in north central Florida.

As a qualitative study, this project was not designed to be statistically generalizable to the U.S. as a whole; nonetheless, in studying these two regions comparatively, I hoped to get a better sense of the major trends in maternal embodiment overall, as well as to see how they played out in divergent local contexts. In each state, I was based in a city with a large, public state university, frequently traveling up to an hour’s drive away in order to reach mothers living in outlying areas. Additionally, both states boasted impressive agricultural economies: California is the single largest agricultural producer in the U.S., and Florida is one of the top producers of fruit and vegetable crops (USDA 2011). Furthermore, due to their agricultural production and temperate climates, California and Florida ranked among the top states to have winter farmers’ markets in 2010 (placing second and fourth out of all fifty states, respectively) (Jones-Ellard 2010). These factors may have caused mothers in my study to have had greater-than-average year-round access to fresh fruits and vegetables, possibly enabling them to have healthier eating habits and lifestyles than mothers in some other parts of the country.

Apart from these similarities, though, I selected these two regions on the basis of several key differences. In California, I based my research in a politically progressive stronghold (known for being so even within a historically Democratic-leaning state), while my Florida research site was located within the most politically conservative region of the state. Demographics were also important, with the California site being multiethnic and urban, while the Florida site was—with the exception of the university town itself—highly rural, and characterized by a largely Black-

White racial makeup. The Southeast region of the U.S. tends to have the country's lowest rates of breastfeeding and maternity care, while the West is strongest on these measures (CDC 2007; CDC 2010). Furthermore, in contrast with the middle-class "foodie" culture of the Bay Area, my Florida site was, both culturally and geographically speaking, a part of the Southeastern U.S. Poor Whites in the region proudly referred to themselves as "crackers," and subjects from middle- and lower-class backgrounds alike referenced family traditions of Southern comfort foods like fried chicken and grits.

Recruitment and Participant Observation

Throughout 2010 and early 2011, I conducted one-time, in-depth interviews with middle- and lower-class mothers in the two states. I had a pre-written interview schedule that I used to guide my open-ended questions, but I was also prepared to depart from the written order of questions if a respondent mentioned a significant-sounding topic that I wished to follow up on. I structured the interviews to move in a roughly chronological order, beginning from how women first found out they were pregnant and going through their experiences of being pregnant, giving birth, and infant feeding, ending with questions about their hopes for the body-care values and habits their children would learn as they grew older. Not all women were asked all questions; women who had never attempted to breastfeed were not asked about breastfeeding, for example, and those whose children were too young to eat solid food were not asked about the child's diet. I developed near-identical interview questions for middle- and lower-class mothers, with the exception of my first set of questions. In order to warm respondents up for the interview, I always began by asking them about how they became involved with the group through which I had recruited them, and how they felt about it.

I elected to recruit women for these interviews through a variety of local organizations catering to the needs of new and expectant mothers. To make contact with middle-class mothers, I requested—and received—permission to post a flier for my project on regional Internet communities for parents, all of which had highly active memberships, organized local events for mothers, and provided forums, message boards, and web links for parenting support. I also took advantage of invitations to come observe in-person meetings of two activity and support groups for mothers: in Florida, an area meeting of La Leche League (a support group for breastfeeding mothers and their children) and, in California, a "baby boot camp" exercise program for new mothers trying to establish regular exercise routines after giving birth. In each, I gave a short presentation on my project and handed out my contact information to women who expressed interest in participating; I also carried out informal participant observation, exercising and completing worksheet-based activities alongside the mothers and—when feasible—having casual conversations with mothers about their participation in this and other mothers' groups. I conducted my interviews with these women outside of the group setting, however, and—when we had finished—I initiated snowball sampling, asking them to pass my name on to other women they knew who might wish to participate. I recruited roughly equal numbers of middle-class women through my initial contacts in listserves and mothers' groups and through follow-up snowball sampling, for a total of 36.

Neither the in-person support groups for mothers nor the online communities were formally limited to middle-class mothers, although the "baby boot camp" did require a paid membership. However, I anticipated that I would have difficulty recruiting poor and working-class mothers in this way, and my expectations proved to be correct. In order to target low-income mothers, then, I moved my recruitment and participant observation to offices of the

Women, Infants, and Children (WIC) program. WIC is a federal, means-tested program run by the U.S. Food and Nutrition Service but administered largely at the state and local levels. As I will describe further in the next chapter, WIC provides food and nutrition assistance to low-income women, infants, and children who are at or below 185% of the federal poverty line.³ I selected eight total offices from which to recruit women for interviews: four offices in different counties in the San Francisco Bay Area, and four offices in different counties in rural northern Florida. I spent about a week of nonconsecutive days at each of the eight sites, observing nutrition education classes and one-on-one counseling sessions, entertaining children in the waiting rooms while their parents filled out forms, and conducting interviews with staff members during down time. I also handed out short surveys to mothers sitting in the waiting rooms and gave them the option of listing their name and phone number if they'd be willing to be interviewed. 75% of the women agreed to be contacted. I called them at home and, of those, I ended up conducting in-depth interviews with 34 women in their homes, in cafes, and in public parks and playgrounds.

Although my observations of middle-class mothers' groups were minimal and informal, I decided to make a more formal study of nutrition instruction at WIC. At the time I began planning my recruitment at WIC, I started to examine the existing literature for research conducted at WIC. However, despite the fact that more than half of all children in the U.S. will receive WIC aid at some point in their first five years of life, I was unable to find a single sociological study that focused on WIC specifically. Indeed, while untold ink has been spilled on the debates over welfare policies like Aid to Families with Dependent Children (AFDC) and its successor, Temporary Aid to Needy Families (TANF), WIC has maintained an exceptionally low profile in scholarly and popular media. For this reason, I decided that my study must also address WIC directly, to understand its role as a key state intervention in the health and lives of low-income American women and children.

In the California WIC offices, I was granted access by office supervisors in each site. Some took a more hands-off role, approving my request to observe and then leaving me to fend for myself. Then, I would usually begin my fieldwork by sitting in a waiting room along with the clients, handing out recruitment surveys and jotting fieldnotes about what I could see of the office. In all cases, however, sooner or later a supervisor or sympathetic other staff member would take me under her wing (it was always a woman). These staff members invited me to sit in on group classes they were teaching, offered short explanations to me regarding terms or methods they used, and made introductions for me to other staff members or clients. Without exception, these women cared deeply about the work they were doing and wanted to make sure I got it right. In Florida, getting access to WIC offices involved considerably more bureaucracy; as part of a university-affiliated health care system, several counties' WIC departments were under the authority of a single, centralized office. Before I could set foot in WIC offices in Florida, I had to undergo a battery of immunization boosters and titers (to test my preexisting immunity against disease), as well as complete an online ethics course on the medical confidentiality laws set forth in the Health Insurance Portability and Accountability Act of 1996 (HIPAA). In short, I completed the same sort of prerequisites as a medical student might before beginning work in a university health clinic. Once thus vetted, though, the central WIC office arranged a packed schedule of WIC office visits for me. Unlike in California, Florida WIC offices were not open

³ In 2010, this cutoff was equivalent to an annual income of \$40,793 for a family of four.

every day; with a smaller, more spread out population, WIC staff rotated between offices, and my schedule ensured that I would be where the clients and staff were going that day.

Subjects

Ultimately, the women I interviewed represented a wide range of ages, life experiences, racial/ethnic backgrounds, and class positions. I developed my initial class categorizations based on whether or not subjects were eligible for WIC. This initial classification scheme formed the basis for my recruitment efforts: because WIC serves roughly half of all American households with young children, this cutoff served as a handy divider between the upper and lower socioeconomic halves of my sample.

In both regions, nearly all of the middle-class (Non-WIC) mothers were married to the fathers of their children; they tended to be in their late 20s to early 40s, and their household incomes placed them well above the cutoff for social relief services like WIC. In contrast, most WIC-enrolled mothers in both regions were single, quite young (on average, almost a decade younger than non-WIC mothers), and, necessarily, much lower-income than WIC-ineligible mothers. In both California and Florida, 88.9% of higher-income mothers had college degrees or higher; in the lower-income group, only 9% of California mothers had completed college, and 21.7% of Florida mothers had done so.

Education forms an important component of class, and so—for the purposes of my analysis—I then divided my initial sample into three groups. The majority of women stayed in the categories I had first assigned them to (30 middle-class mothers in my middle-class category, 27 poor and working-class mothers in my lower-class category). However, a significant minority of women showed evidence of past or potential future class mobility, which complicated my classification scheme.

From my initial categories, 13 women did not neatly fit into an upper/lower class dichotomy. These mixed-class mothers, as I will call them, included low-income women with advanced degrees, higher-income women without a college education, or—in a handful of cases—women whose interviews revealed a significant difference between their current class and their class during childhood. Of the mixed-class subjects, six were upwardly mobile (non-WIC-eligible due to education, success in a career, or both) and seven were downwardly mobile or temporarily low-income (WIC-eligible but well-educated, often true for women who had limited incomes while finishing advanced degrees or while taking time off work while their children were very young). These women's stories complicate the class picture in some ways, but reinforce it in others. Well-educated women in WIC, for example, were much more likely to cite childcare values and modes of agency that aligned much more with a middle-class cultural position than with patterns more typical of low-income mothers. Likewise, upwardly mobile mothers tended to speak more consciously about class than their middle-class peers, often noting ways in which they did not quite “fit” or—perhaps on the flip side of the same coin—embracing middle-class cultural values passionately, as if to reaffirm their position in this status group. Women in this mixed-class group were often quite candid about money, being among the most likely to note how their self-care values and habits were sometimes hard to reconcile with limited budgets. In this way, their stories emphasize the continuing interaction of financial and cultural contributors to class.

One caveat to my sampling methods is that using WIC exclusively to recruit low-income women may lead to certain patterns that might not be present among low-income women as a whole. As noted before, WIC participation is quite broad, with approximately half of all U.S.

children having participated before the age of 5 (Oliveira et al. 2002). On the other hand, Bitler, Currie, and Scholz (2003) find that WIC participants are more likely than the general WIC-eligible population to be Hispanic and to be married, and less likely to be Asian or to live in the inner city. Additionally, women who enroll in WIC are more likely than eligible non-enrollees to breastfeed (Schwartz et al. 1992), and those who have been in the program for some time are, as a result, more likely to be well acquainted with mainstream health norms including, but not limited to, breastfeeding. At the same time, my own ethnographic observations and interview data suggest that women at the upper end of WIC-eligible incomes might be less likely to participate: most mothers had been referred to WIC through other programs for low-income women (which, typically, had lower income cutoffs than WIC), and several non-WIC mothers told me that they might have been eligible for WIC in previous years, but they had chosen not to investigate because they felt those services were for people who “really needed” them. In short, while there may be some non-random differences between eligible WIC participants and nonparticipants, I found nothing to indicate that those differences would significantly impact my findings in one direction or another.

Finally, while I took pains to recruit an ethnically diverse group of women for my interviews, it remained the case that most of my middle-class respondents were White, and more than half of my poor and working-class respondents were not. To the extent that such comparisons are possible, I have looked carefully for racial/ethnic differences in response patterns. Still, my findings mainly indicate the importance of class differences among women.

Likewise, while I selected my research sites in California and Florida to explore the role of regional and geographic influences on women’s experiences of maternal embodiment, I was struck by the similarities between the stories I heard from women from both states. For this reason, subsequent chapters mention respondents’ state of residence, but they do not highlight state differences. The one major difference between states that I found was in the distribution of mothers across class. In California, very few women existed on the border of being middle- or lower-class. Financially speaking, the area’s residential neighborhoods tended to be fairly segregated, with insular urban, upper-middle-class neighborhoods existing in close physical proximity to, but culturally distant from, poor and working-class neighborhoods in the same city. Not one WIC-eligible California mother responded to my postings on general-interest parenting websites, and (less surprisingly) my snowball sampling from middle-class mothers did not yield a single lower-class respondent. In Florida, class boundaries seemed to be relatively permeable (or, at least, to be based on different criteria than those in California). College-educated mothers spoke fondly about the same beloved comfort foods that working-class mothers with high school degrees mentioned. Several of the WIC mothers in Florida were married, and had become eligible following their decision to stay at home full-time with their children. In their culture, if not their finances, these women leaned toward the middle class. Finally, when I made online recruiting pitches to parenting listserves in Florida, a handful of WIC mothers responded to the call. Whatever else this pattern means, it suggests that California mothers tended to be more segregated than Florida mothers economically, culturally, and even in their use of online parenting resources and communities.

Contributions

My aim, in this dissertation, is to show the two sets of orientations toward—and consequences of—the care of the body that emerge among middle- and lower-class mothers in the U.S. What is striking about this pattern is that many of the accepted norms for “good”

motherhood, healthy behavior, and moral management of the body are shared across racial/ethnic, geographic, and socioeconomic lines. As described earlier in this chapter, neoliberal ideas about the importance of self-care are widespread. And yet, the resources and cultural repertoires with which women approach the project of self-care during maternal embodiment vary widely.

Poor and working-class women, particularly those who receive government assistance with food and childcare, are exposed to a fairly unified set of norms regarding the care and cultivation of the maternal body. In WIC, women often come to identify with and adopt those norms—and the particular health habits they require—due to the agency’s strategy of *gentle discipline*. Unlike government agencies like TANF, which use punitive sanctions to reinforce desired neoliberal behaviors among low-income clients, WIC reaches out to mothers in the program by providing empathetic counselors, interpellating mothers as nutritional authorities in their own households, and superficially personalizing food packages while nevertheless reinforcing a single standard of healthy eating and behavior.

Outside of the WIC office, lower-class mothers adopt a pragmatic approach to self- and child-care. While they often attempt to abide by the recommendations of their WIC counselors, obstetricians, and pediatricians, those efforts are tempered by a clear-eyed assessment of which changes are possible given their current time and financial resources. In some sense, these mothers’ approach is nominally neoliberal: it involves ongoing assessment of the costs and benefits of particular body care practices given limited resources, making decisions about their own health and that of their children via what I call *flexible agency* (an alternate mode of action that, I argue, is often misrecognized as an absence of agency). Yet while such cost-benefit analyses align with some of the principles of neoliberalism, they fail to achieve the neoliberal/biomedical pursuit of the *optimization* of human life and human capital. Accordingly, given their more limited social and economic resources for pursuing every opportunity to maximize their children’s developmental and life outcomes, these women may still be judged by the wider world as failing—as mothers, and as full neoliberal citizen-subjects.

Middle-class mothers, too, are disciplined to embody particular norms for good motherhood and health cultivation, though the social institutions through which this discipline is transmitted tend to be more informal than WIC. Online parenting message boards, new mother support groups (“mommy groups”), exercise classes, and other such sites provide a forum for middle-class mothers to address one another’s questions and commiserate about the difficulties of maternal embodiment. As with WIC, these sites tend to be fairly class-homogeneous. Unlike WIC, though, the particular normalizing discipline of middle-class mothers—what I call *questing discipline*—leans toward a multiplicity of possible best health and parenting practices. Questing discipline centers on the imperative that mothers keep searching for the next new thing. At the same time, this discipline holds that the specific “best” approach for a mother and her child is not universal but, rather, is painstakingly personalized to the individual needs and bodies of those involved. Managing the body in this way requires that women intensively self-scrutinize how their bodies feel, analyze the outcomes of different diet and exercise practices, and make incremental adjustments in those practices accordingly. The focus of this project is not, then, one standard of health, but ongoing optimization.

Whereas the neoliberality of lower-class mothers’ practices involves careful weighing of the costs and benefits of a given health habit, middle-class mothers are less attuned to the cost side of that equation. These women’s educational and socioeconomic advantages often turn the question of *if* they will pursue a desired health practice into a question of *how*. In this way, they embrace the principle of neoliberal self-improvement that emphasizes constant optimization of

the human body and human capital at all costs. As such, they treat bodily setbacks or inconveniences (stalled labor, breastfeeding difficulties, etc.) as barriers to be overcome in pursuit of the perfect pregnancy and optimal developmental conditions for children. The single-mindedness with which middle-class mothers pursue their goals, maintaining a coherent vision while pushing past obstacles to that vision, I term *rigid agency*.

While health is the most obvious benefit of middle-class mothers' body-care projects, a second benefit is tied to status. In developing personal body projects that reflect their expertise and determination, these women adopt health as a *moral lifestyle*, which in turn acts as a marker of cultural distinction. Specifically, what they practice and model for their children—in some cases explicitly aiming to teach this to their children—is a way of approaching the body and health as an ethically driven, self-significant life project, less about the particular benefits to be gained by any one health habit than the ongoing practice of keeping up with the latest trends and discoveries in health research, becoming an expert for oneself, and knowing how to personalize that research to fit one's own needs and lifestyle. Not only is this project potentially expensive and time-consuming, but, I argue, it does the work of marking individuals as culturally middle-class.

Meanwhile, lower-class mothers strive to teach their children about health, and through their flexible agency they model the useful skill of adaptability. With the financial assistance and nutrition education provided at WIC, they, too, work to cultivate the health and bodies of their children. What is missing in that aid, however, is an education in the middle-class culture of constant self-maximization and indifference to potential costs (a deficit that would require much more than the semiannual 15-minute nutrition consultation and monthly food coupon booklets that WIC provides). Thus, while programs like WIC do the important work of helping to improve health and body care knowledge in poor and working-class families, the middle-class ability to use the body as a marker of cultural distinction remains untouched.

Organization of the Dissertation

In the chapters that follow, I will elaborate different pieces of my central argument: namely, that, in the contemporary U.S., the care and cultivation of the body have become a critical means through which social status is maintained and transmitted, and that this process is particularly intensified for new mothers and their children. In Chapter Two, I analyze the history and policy of the WIC program alongside discussions about maternal body care from both WIC staff and mothers. Describing the program's unique tactic of *gentle discipline*, I argue that bodily self-care has become a central value for being judged as a worthy citizen-subject, which then informs the ways in which WIC addresses its poor and working-class clients.

In Chapter Three, I turn to the self-cultivation practices of middle-class mothers. Engaging with informal mothers' groups, doctors' advice, and their own self-directed research, these women work to become lay experts on self-care and to meet the demands of the *questing discipline* of their class. Questions about citizenship and subjectivity rarely arise for these women, since their actions are more likely to fall in line with the demands of neoliberal governance (and to be read as agency, a point I will discuss in the subsequent chapter). Rather, middle-class mothers deploy bodily cultivation as a way of affirming a unique and personalized self-identity, often with the effect of asserting status vis-à-vis other mothers.

Chapter Four introduces the first direct comparison of middle- and lower-class mothers' attitudes toward self-care practices and knowledge. Women across classes tell different stories about their bodily choices—middle-class mothers tend to assert the rightness of the choices they

have made and the expertise they have cultivated along the way, while lower-class mothers are more likely to note the challenges and setbacks they have faced. These differences notwithstanding, I argue that both types of narratives provide insights into the ways that mothers work toward a widely shared set of health values. Where working- and middle-class mothers differ is in the forms of agency they espouse, and in the relative cultural legibility of that agency. I suggest that this may have consequences for their ability to be read as good mothers, and for health care providers and other authorities to support their efforts.

The fifth and final chapter shifts focus from the consequences of mothers' self-care strategies for themselves to the future health practices and values they imagine for their children. Contrary to the poor cultural values for food and exercise that lower-class Americans are popularly believed to hold, I found, among my respondents, a passionate concern for the health of their children, and a fairly unified sense of what healthy living might entail. Middle-class mothers, on the other hand, demonstrated no such shared dedication to a particular plan for cultivating the body. Instead, they spoke of teaching their children to become knowledgeable consumers with varied palates, well-informed about the sources and contents of their food. On one hand, this middle-class cultural value reflects legitimate concerns about health: given constantly shifting scientific opinion on self-care, one day's health food can become the next day's junk food, and children will need to learn to keep up. On the other hand, I argue that middle-class mothers' preoccupation with teaching their children to be informed consumers is also a means of status transmission. As in other areas of life, middle-class subjects tend to be the early adopters of new dietary and exercise regimes; teaching their children to remain on the cutting edge of such trends provides those children with access not only to health, but also to cultural *distinction*.

Conclusion

In this project, I show how neoliberal norms for citizenship in the contemporary United States place differential demands on mothers of different class positions, and with different consequences. For poor and working-class mothers, correct care and management of the body offer a chance to be recognized as self-controlled citizens, fulfilling an obligation to society to be neither too unhealthy, too expensive, nor too needy. Programs aimed at their care of their children seek to increase those obligations in the next generation. By contrast, middle-class mothers ably fill the role of self-optimizing neoliberal political subjects, "whose citizenship is to be manifested through the free exercise of personal choice among a variety of marketed options" (Rose 1990: 226). At stake in their own self-care habits and beliefs is not their social citizenship, but their continuing status as members of the middle and upper classes. Even as the market offers these women greater opportunity to bolster their self-identities through informed choices about consumption and self-cultivation, the perceived risks to those self-identities—through personal failure to follow through on one's self-care goals, or through the competing modes of body cultivation espoused by other mothers—become comparably great. Despite (and also, sometimes, because of) seemingly unlimited choices, many of these mothers feel themselves locked into a struggle they never chose; every bodily decision holds consequences for their child's future success and happiness.

Ultimately, whether the stakes of mothers' self- and child-care habits revolve around citizenship or status, the maternal body has become a major arena in which to witness the personal implications of living in a neoliberal society. The trick of neoliberalism—the "irony," as Rose (1990) points out in the quotation that began this chapter—is to make us "believe...that

we are, freely, choosing our freedom.” In a world where lower-class mothers are formally permitted to choose their self-care habits but where social welfare programs like WIC gently and firmly guide them toward the “correct” choices as neoliberal citizen-subjects, where middle-class mothers confront a vast array of body-care techniques and products on the free market but where each choice has the potential to enhance or detract from their own or their child’s status, we might ask how helpful it is to judge any of these choices as *free*, or to assume that middle-class mothers’ choices are inherently more so. Challenging discourses that pose middle-class subjects as agentic actors and lower-class subjects as “acted upon,” and, furthermore, confronting the classed underpinnings of popular judgments of “good” and “bad” mothers, this dissertation shows how all mothers act in the presence of structural and ideological constraints on that action. All navigate among their available options (wider or narrower though those options may be) and, adopting diverse modes of agency, strive toward better health and happiness for themselves and their children.

CHAPTER TWO

Neoliberal Bodies, Subjectivity, and the State: Nourishing Citizens in the Women, Infants, and Children Program

When I first began my fieldwork in early 2010, child health and nutrition in the U.S.—childhood obesity, in particular—were topics of considerable public concern. In February of that year, First Lady Michelle Obama launched the “Let’s Move!” antiobesity campaign for children, an initiative that emphasized the importance of weight management and exercise for all children even as its programs targeted the causes of health and weight disparities between low-income and middle-class U.S. youth. Local governments debated bans on soda machines in grade schools, and celebrity chefs like Jamie Oliver and Alice Waters proposed programs to introduce children in inner city schools to healthy, varied cuisines. Alongside these higher profile solutions, however, one of the nation’s most wide-reaching and influential food assistance programs underwent a quiet overhaul. That institution, at which I ended up conducting nearly a year’s worth of ethnographic observation, was the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC).

Of the many possible programs addressing health and nutrition that I could have studied, I became interested in WIC because of its joint focus on maternal and infant body care in low-income populations. Intervening at a critical time—when women are pregnant or recently postpartum—WIC seeks to set the stage for healthy childhoods and beyond. Additionally, more so than the aforementioned local health initiatives or even national programs like the Supplemental Nutrition Assistance Program (SNAP, or Food Stamps), WIC serves as a major conduit for state- and medically-approved norms for health and nutrition to reach low-income mothers. Not all eligible mothers and children participate in WIC, but the majority do: over half of all children in the U.S. receive WIC aid at some point in their first five years of life (Oliveira et al. 2002). As of the early 2000s, 73.2% of eligible households with an infant received WIC assistance, and 66.5% of eligible women who were pregnant or postpartum did so (Bitler, Currie, and Scholz 2003).

WIC exists against a backdrop of large health disparities between classes in the U.S., and as a means-tested welfare program, some of what it seeks to provide are the financial means to buy nutritious foods. But WIC does not merely provide these foods; it seeks to shape attitudes towards diet and exercise among low-income mothers and their communities. Thus, WIC’s efforts are not just about providing preventative care and food resources, but also about changing values and lifestyles. In this chapter, I will argue that even as mothers and staff at WIC work together to optimize women’s and children’s health, they are also engaged in discursive negotiations over what it means to be a “good” mother, an adult, and a full citizen-subject.

As such, this chapter enters into conversation with literature on the welfare state more generally, where scholars have argued that welfare policy operates to endorse particular forms of citizenship. According to this argument, social provision tends to come with strings attached, in the form of (for example) eligibility rules and penalties for noncompliance with program guidelines. Close analysis of those stipulations, then, can reveal information about how the state thinks of its poor and working-class subjects, and how it would like them to behave. I use the case of WIC to examine how the state constructs its ideal subjects through particular practices of bodily self-care and nutrition, and I ask: if welfare policy can show how the modern U.S. state

relates to and constructs its subjects, what kinds of embodied subjects does WIC seek to create from its poor and working-class clients, and through what techniques and ideologies?

Ultimately, though WIC mothers are gendered, classed, and racialized individuals, I argue that WIC policy refashions them as neoliberal subjects whose key characteristics are frugality, autonomy, and bodily self-care. Analyzing WIC policy documents, conducting ethnographic observations in WIC offices, and interviewing both staff and clients, I find that WIC pursues its aims through what I call “gentle discipline”: the use of care, personalized attention, and a discourse of empowerment to elicit mothers’ compliance with health and nutritional standards. While mothers benefit from the carework that WIC staff members perform, not to mention the free food they receive, the program also works to attain mothers’ consent to culturally hegemonic body-care values. In exchange for that consent, WIC-enrolled women gain the chance to win state recognition as good mothers and as neoliberal, body-cultivating citizen-subjects.

Subjects, Citizens, and the State

As discussed in the Introduction, social norms, opportunities, and constraints operate to construct individuals as particular kinds of subjects. Michel Foucault, a progenitor of the concept of subjectification, describes how the state elicits those subjects: rather than existing at a distance from its subjects, the modern state developed “as a very sophisticated structure, in which individuals can be integrated, under one condition: that this individuality would be shaped in a new form and submitted to a set of very specific patterns” (Foucault 1982: 783). Critically, Foucault notes that the institutionalized powers that contribute to subjectification are varied: the state may play a role, but so too do capitalism, family, and medical authority, to name a few (Foucault 1982; [1977] 1995). The term “subject,” then, is deliberately broad. However, when subjectifying power in the contemporary era operates through the state (as opposed to other social institutions), the resulting subject may not only be the target of power, but may also become empowered to make claims on the state—in short, may become a *citizen*. How, then, do state welfare programs construct their participants as subjects of state power? When, if at all, do they make those subjects legible as citizens?

Anna Korteweg (2006) suggests that the processes of making subjects and citizens are intertwined within welfare programs, where policies work to shape participant behavior with the promise of social recognition to those who can meet program-endorsed norms.

[C]itizenship, much like social policy, is partly constructed at the “street level,” where particular bureaucratic practices are conduits for the signs through which citizen-subjects are recruited...The signs that recruit subjects...also delineate the bases for such belonging, defining good citizenship and becoming part of the subjectivity that welfare-reliant women perform in their interactions with the state. (Korteweg 2006: 335)

In its broadest sense, the concept of “citizenship” refers to a status of belonging to a particular society or body politic. In popular usage, this word refers to *political citizenship*, a type of belonging that is premised on national origin or naturalization, and which indicates the formal rights and responsibilities of those within its jurisdiction. Scholarship on political citizenship in the contemporary United States and elsewhere often focuses on immigration policies and debates, noting the processes of state-sponsored boundary-drawing between citizens

and non-citizens. Yet, debates over boundaries and belonging occur *within* states as well as *across* them; despite the promise of equality in the founding documents of the U.S., formal political citizenship does not guarantee much in the way of a baseline quality of life.

In response to ongoing material inequality in the U.S., scholars such as T.H. Marshall ([1949] 1998) and Nancy Fraser and Linda Gordon ([1992] 1998) have advocated that the U.S. expand on its provision of formal rights and responsibilities via political citizenship toward something they call *social citizenship*: “a welfare state citizenship [that] includes an entitlement to social provision—the guarantee of a decent standard of living” (Fraser and Gordon [1992] 1998: 113). This proposition is controversial, and, at the close of the 20th century, neoliberal forces within the U.S. had pushed, with some degree of success, to limit or eliminate longstanding entitlement programs within the U.S. welfare state.

As the quotation from Anna Korteweg indicates, looking at trends in social welfare policy can reveal a great deal about a society’s current anxieties and moral panics, which influence the shifting terrain of who becomes legible as a citizen-subject and who can, thus, access the rights and responsibilities that entails. As the following section will show, looking at the history of the U.S. welfare state reveals a host of exclusions centering on race, class, women’s sexual morality, and the generally degraded status of “dependency.” Finally, as the rare relief program whose *expansion* during the early 2000s has been the exception to the rule, WIC highlights both contemporary social anxieties about the unruly bodies of the poor and the increasing salience of health and wellness for social inclusion.

The Paternal Welfare State: Defining and Disciplining Women as Citizen-Subjects

For the purposes of this chapter, I divide the history of 20th-century U.S. welfare into three eras: (1) Paternalism and Respectable Mothers; (2) Welfare Rights and the Specter of the Welfare Queen; and, post-welfare reform, (3) Neoliberalism and Personal Responsibility. I suggest that each era has had its own dominating image of the aid recipient mother, and that, following demographic changes in the population of aid recipients and ideological responses to such change, welfare policy gradually has moved from *reacting* to the imagined characteristics of recipients to actively *shaping* and *creating* them into its desired subjects. Critically, these shifts have the potential to affect the lives of welfare-reliant and non-welfare-reliant women alike. As Sharon Hays (2003) argues, welfare disciplines not only those who receive it (or even those who are eligible to receive it), but also the rest of the population: welfare policy “provides a reflected image of American culture and reinforces a system of beliefs about how *all* of us should behave” (Hays 2003: 9). Accordingly, welfare policy provides helpful clues for identifying the shifting norms and values associated with citizenship in the U.S.: it is in the state’s day-to-day dealings with its marginalized subjects—the people presumed to lack those norms and values—that the meanings of citizenship are made plain.

Paternalism and Respectable Mothers

During the early years of the 20th century, the U.S. began to provide modest stipends for so-called “respectable” women to stay home, raising their children and conforming to the prevailing cult of true womanhood and domesticity (Gordon 1990; Misra and Akins 1998; Orloff and Skocpol 1984; Skocpol 1992). As these scholars point out, the state essentially stepped in as a substitute husband-father figure for women in the programs. However, just as the separate spheres ideology of gender difference was premised on a racialized and classed figure of the “true woman,” so too were the welfare programs that relied on that ideology. Under the state-

administered Mothers' Pensions of the 1910s-1920s, the criterion of "respectability" tended to limit benefits to White women who had been widowed or abandoned, while excluding non-White women and those who bore children outside of marriage. The Aid to Dependent Children (ADC, later AFDC) Program, which began in 1935 as part of the Social Security Act, nationalized these benefits. Continuing into the 1960s, welfare recipients' eligibility continued to be determined by caseworkers in an arbitrary, often blatantly discriminatory manner.

Welfare Rights and the Specter of the Welfare Queen

In the 1960s, the Welfare Rights Movement challenged the exclusionary nature of social relief programs at the time. Instead of mere political citizenship, Welfare Rights backers argued for what they called "social citizenship," which would guarantee basic economic stability for all members of society as a right (Gordon and Fraser [1992] 1998; Marshall [1949] 1998). Welfare rights organizations published pamphlets to demystify welfare's eligibility guidelines, and some brought lawsuits to fight exclusionary treatment. As a result, welfare participation greatly increased. One outcome of these events was that the welfare rolls became disproportionately women of color, due to the racialization and gendering of poverty (Korteweg 2006). And, as the face of welfare changed, so did institutional discourses about welfare recipients, and the responses to recipients as particular kinds of subjects. Welfare came to be seen as a *cause* of poverty, rather than a solution, and in place of the "respectable" woman of the Mothers' Pensions era the central figure of public assistance discourse became the "welfare queen." Caseworkers strictly enforced man-in-the-house regulations, which prevented women who lived with a husband or boyfriend from receiving aid. Poverty alone was not sufficient grounds for eligibility; rather, the state would step in as a provider only when the husband/father was not present (Piven and Cloward [1971] 1993). This rule served both to ward off supposed welfare "cheaters" who, presumably, were supplementing welfare with support from a live-in partner, and to police sexual morality, perhaps trying to recreate the "respectability" of mothers in the previous era (Hays 2003; Roberts 1997; Smith 2007).

Welfare in the 1960s through the 1990s was thus marked by a number of tensions: federal policy still positioned the state as a masculine provider for dependent mothers and their children, but increasing diversity among welfare recipients led to a shift in how they were portrayed. From respectable angels of the home, they had now been reimagined as promiscuous, lazy cheats, and by the 1980s, Ronald Reagan's image of the Cadillac-driving "welfare queen" had been born.

Personal Responsibility and the Neoliberal Welfare Subject

These tensions came to a head in the 1996 Welfare Reform, known as the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA), when the U.S. government essentially filed for divorce to escape its husband-provider role. Under the new Temporary Aid to Needy Families program (TANF), poor single mothers would now be required to name the fathers of their children for the purposes of child support payments (Hays 2003; Mink 1998) and also encouraged to marry those men, thus supplanting the mother- and grandmother-headed households common in low-income and racial/ethnic minority communities with ostensibly self-sufficient nuclear family units (particularly under the 2002 Healthy Marriage Initiative, described by Randles [2011]). For single women, stay-at-home motherhood has been replaced by an ideal of working motherhood, with participants now being required to attend job-training workshops during their time in the program (Hays 2003; Korteweg 2006). Most significantly, this newly christened "workfare" imposed a number of restrictions on participants.

Women were now restricted to a 5-year lifetime limit on benefits, and those deemed noncompliant with the demands of the program could lose their benefits for a period of time (while still having that time count against their lifetime limit).

Many scholars of the welfare state (e.g., Korteweg 2006; Lister 2002) have interpreted these policy changes as establishing a genderless, independent, self-sufficient worker as the citizen-subject for the contemporary period: one in line with neoliberal social and economic policies. According to these analyses, motherhood has been delegitimated as a basis for full social and economic inclusion (at least among the lower classes); the largely female domain of carework has been rendered invisible; and the sole means of gaining recognition as a citizen is through paid work. Describing how recent reforms to welfare policy serve the needs of a capitalist society, Ruth Lister writes that they are “designed to shift responsibility for family welfare from the state to individual families and to promote paid work as the best source of welfare and as a primary responsibility of citizenship” (2002: 127).

For many observers of the welfare state, the 1996 welfare reforms (turning welfare into “workfare”) and the rise of neoliberal logics are leading to the death of welfare or, at the very least, a considerably minimized and altered role for it to play: in the words of President Bill Clinton, at the time PRWORA was signed into law, there would be “an end to welfare as we know it.” In a welfare economy, writes Foucault, redistributive policy “is conceptualized as a counterweight to unrestrained economic processes which it is reckoned will induce inequality and generally destructive effects on society if left to themselves. So, the nature of social policy should be a kind of counterpoint to economic processes” (1982: 142). This perspective places the state and the market in complementary roles, with the state working to curb the worst excesses of the market and to ensure that the majority of the population will have the means to consume the products of capitalist enterprise. Under neoliberalism, however, “social transfers [e.g., cash assistance] are of a very limited character. Broadly speaking it is not a matter of maintaining purchasing power but merely of ensuring a vital minimum for those who...would not be able to ensure their own existence” (p. 143). Loïc Wacquant (2010) agrees with Foucault that the rise of neoliberalism is linked to the “devolution, retraction, and recomposition” of the welfare state, and adds that its new goal is to “submit reticent individuals to desocialized wage labor via variants of ‘workfare’” while managing poor and working-class unrest with an expanded prison state (p. 213). Furthermore, with the move from “people processing” to what Wacquant describes as “people changing,” (p. 203), the remaining welfare state has taken a far more active role in creating the subjects for a neoliberal society.

Neoliberal Citizenship and the Body

The rise of neoliberal logics within the welfare state and the state more generally is most often associated with a push for greater personal economic responsibility, a trend that can be seen in the transition from welfare to “workfare.” However, the logic of economic self-maximization carries into the personal sphere an injunction to fine-tune and maximize one’s personal “capital,” including one’s very body. In the neoliberal era, bodily self-cultivation is not a mere individual preference, but the responsibility of all citizens. As will be discussed further in the next chapter, bodily care and cultivation have long served as hallmarks of middle-class subjecthood and as sites of distinction for the middle and upper classes. And, while self-care has become a key component of neoliberal citizenship and belonging, it exists in the context of a longer history in which people have used practices of body cultivation to set themselves apart or to seek social inclusion.

Randolph Hohle (2009) describes one instance of body-based claims to citizenship by marginalized groups, focusing on the self-cultivation habits taught by activists within the 1960s Civil Rights Movement. According to Hohle, reformist civil rights groups like the Southern Christian Leadership Conference (SCLC) and the Student Nonviolent Coordinating Committee (SNCC) used their bodies to perform *idealized citizenship*, which he defines as “how a nation prefers to see itself in relation to a set of universal and idealized cultural values and beliefs, which define who counts as the good citizen” (p. 287). Whereas radical Black nationalists used their bodies to emphasize *difference* from this ideal (by growing their hair long and wearing African-styled clothing), the reform-minded SCLC and SNCC taught their members to perform *assimilation* to hegemonic modes of comportment and bodily self-control. These embodied practices included: managing one’s outward displays of emotion, maintaining impeccable hygiene and dress, and mastering “speaking styles and tones that produced deracialized bodies representing good black citizens” (p. 289). Indeed, though Hohle does not highlight this point, these groups’ pedagogies taught movement participants to emphasize *sameness* not only through bodily gestures, but also through the performance of a hegemonic gender binary. While, during the Freedom Summer of 1964, women were taught about hygiene and infant care, men were schooled in home maintenance and ways of dealing with state agencies. By placing women squarely within the home while positioning men to make improvements to that home and to interface with the public sphere, these approaches perhaps also sought to assuage public fears about the supposedly non-normative gender dynamics of Black working families. This practice is sometimes called *anticipatory socialization*, in which members of subordinate groups mimic the appearance and mannerisms of members of the dominant group in order to facilitate upward mobility (Merton and Rossi 1950).

In many ways, Hohle’s research subjects could be described as seeking to change their “class bodies,” a term Pierre Bourdieu ([1977] 1984) devised to note how class and status differences in society lead to class-differentiated cultural norms for bodies. What Bourdieu theorized, and what the subjects of Hohle’s research also seem to have intuited, is that habits of personal care and appearance are not matters of individual taste, but signals subtly indicating one’s social position and engagement with particular cultural norms.

At the dawn of the twenty-first century, however, normative self-care as a means of accessing citizenship is no longer the tool of civil rights activists; instead, it has become a discourse taken up by the neoliberal state itself. The central problem of these neoliberal criteria for recognition as full citizen-subjects is that they appear both neutral and universally available. However, values like autonomy are both gendered and classed, such that they may be particularly distant from the day-to-day lived experience of low-income women. Carol Gilligan’s (1982) research on gender and moral reasoning associates independence with a more masculine moral orientation, while she finds that women are more likely to value relationality and interdependence. Brown (1995) further argues that a classically liberal focus on formal freedoms and rights often neglects the real circumstances of women’s lack of practical freedoms.

Not only are neoliberal conceptions of citizenship gendered masculine, but also, they are biased toward middle- and upper-class subjects. Catherine Kingfisher (2002) explains how the neoliberal definition of citizenship may exclude welfare-reliant women, in particular:

Poor women...fail to fulfill the requirements of full individuality and autonomy; indeed of citizenship...The failure is attributed to individuals (women) who are always already incomplete and dependent, with the result that poverty policy is

directed at the reformation of individuals rather than structures. The problem, in other words, is not 'capitalism, racism and inequality,' but 'the order of the self and the way we govern ourselves' (Cruikshank 1996:231)." (p. 27)

In the remainder of this chapter, I will outline the ways in which WIC endorses a particular model of citizenship for its clients based on the interconnected norms for “good” motherhood and body cultivation, even as it epitomizes the neoliberal drive to individualize responsibility for care. For poor and working-class women who depend on government aid through WIC, the state is a major (though not the sole) force holding them accountable for their ongoing body projects. As such, the stakes of these projects come to represent access to full citizenship.

Lower-Class Women and WIC: Support and Subjectification

WIC Policy and Practice

When I began my research in WIC offices in California and Florida, my expectations for what I would find had been primed by the U.S. welfare state literature described earlier in this chapter. Common sociological wisdom holds that the neoliberal emphasis on the free market and on individual responsibility has led to a withdrawal of traditional welfare funding (e.g., Lister 2002). At the state level, this withdrawal has been associated with policy changes (from welfare to “workfare,” benefit caps determined by time in the program, and de facto penalties for further childbearing while on public assistance). In welfare offices, these policy changes have created incentives for caseworkers to eliminate clients from the welfare rolls, often leading to distrust or animosity between the two parties (Hays 2003). As I would soon learn, however, much of what the welfare state literature had led me to expect about WIC was wrong.

Subjectification happens at WIC, but it does so in a context markedly different from other well-known welfare programs. Instead of cutbacks, WIC has been steadily growing over the past few decades. Instead of incentives for cutting women from the rolls, WIC maintains an active outreach program to boost participation. And in program offices, in place of the anti-dependency shaming the welfare state literature had led me to expect, I found client-staff relationships based on respect and care. I realized, then, that any attempt I might make to understand the ties between policy and normative prescriptions for the bodies of aid recipients needs to consider not only the contents of WIC policy—having largely to do with health and nutrition—but also both (1) the means and (2) the ideology through which that policy is enacted. In taking this approach, I asked: how might the case of WIC extend—or challenge—existing theories of state power and welfare?

The founding concerns for the creation of WIC were laid out in the Child Nutrition Act of 1966:

Congress finds that substantial numbers of pregnant, postpartum and breastfeeding women, infants and young children from families with inadequate income are at special risk with respect to their physical and mental health by reason of inadequate nutrition or health care, or both. The purpose of the [WIC] Program is to provide supplemental foods and nutrition education through payment of cash grants to State agencies which administer the Program (Food and Nutrition Service 2011: 340).

That mission has stayed more or less constant over the years, such that today, all WIC offices fulfill three basic tasks: (1) distribute voucher checks for specific foods, (2) provide nutrition

education for participants, and (3) conduct outreach and referrals to other social assistance programs.

Both TANF (formerly AFDC) and WIC provide aid to similar populations: families with little or no income, often single mothers and their children. Both programs are means-tested, but their eligibility criteria are different. While TANF and several other relief programs have documentation requirements that are quite strict, sometimes prohibitively so, the WIC staff and clients I spoke to reported that WIC is relatively easy to join. Pregnant or breastfeeding women, as well as infants and children up to age five, are all eligible for WIC, provided they fall at or below 185% of the federal poverty line. The initial intake meeting requires potential clients to provide evidence of residence within the area covered by the WIC office and some proof of income (e.g., paystubs or documentation showing their eligibility for another state relief program). For continued participation in the program, eligible recipients must regularly have their height, weight, and blood iron measured and recorded. Although this chapter argues that WIC is concerned with the production of *neoliberal citizenship*, it is significant that the program's attention to *legal citizenship* is minimal: neither social security numbers nor proofs of U.S. citizenship are ever requested.

Indeed, the program's financial eligibility criteria are so permissive that it includes not only the most desperately poor women and children, but also a number of working families who would be ineligible for other forms of relief like SNAP or TANF. In my fieldwork at WIC offices, I encountered single mothers living in shelters, grandmothers who had become part- or full-time caretakers for their daughters' children, young couples where one or both partners were full-time college or graduate students, and even nuclear families who became financially eligible for WIC when a mother's decision to stay at home transformed them from a dual- to a single-income household. Thus, it would seem that WIC extends its reach far into the homes of poor, working-class, and even borderline lower middle-class households, an important point to keep in mind when examining its simultaneous provision of benefits and promotion of maternal embodiment norms.

WIC exists partly to remedy the health disparities between classes, and it draws women with the promise of free, nutritious foods and infant formula. But WIC does not merely provide those foods. As in Wacquant's (2010) observation that the welfare state has moved toward "active people changing" (p. 203), WIC also seeks to change mothers' lifestyles. A general understanding of the values and attitudes—and the types of subjects—WIC endorses becomes possible when looking at some of the promotional materials distributed through WIC, and at the signs posted outside of WIC offices (see Appendix A). Figures 1 and 2 show billboards posted in low-income neighborhoods and sponsored by the California Department of Public Health, which administers the WIC program in the state. These billboards ("Buy more fruits and vegetables"; "Eat right when money's tight") present images of strong, frugal mothers—most or all of whom appear to be women of color—who proficiently manage their families, budgets, and diets by setting clear rules. Figure 3 shows a similar theme in Florida, in which the Florida Department of Agriculture—another agency with strong local ties to WIC—states, "Tightening your belt doesn't have to be all bad." With this play on words, the advertisement interpellates a subject who is female (with the use of an apparently female body in the image), concerned with her shrinking finances during a period of economic recession, and attuned to her weight. Figures 4, 5, and 6, drawn from WIC promotional materials in Florida (Figs. 4 and 5) and California (Fig. 6), also hint at the futurity of the program's aims: parents are not only learning to eat healthily on a budget, but also being groomed as role models for these same behaviors in their children. Thus,

all of these materials—and similar ones exist for other states—imagine a subject who is frugal, health-conscious, and who takes responsibility for herself and her family.

At the time I conducted my fieldwork in WIC offices in 2010, the program had recently undergone a national overhaul of its nutrition-promoting practices, with major additions to its material support for breastfeeding and low-calorie diets. Throughout the early 2000s, WIC had been steadily increasing its verbal support for breastfeeding, fighting against its longstanding image as “the formula program” (so named for the fact that low-income mothers disproportionately choose bottle-feeding over breastfeeding, and disparaged by breastfeeding advocates for providing those women with free infant formula). By late 2009, WIC had begun to back up its pro-breastfeeding stance with concrete changes in food packages and counseling services it offered.

Today, WIC continues to expend a significant portion of its budget on formula, with each state negotiating an exclusive contract with a single formula manufacturer in order to obtain bargain prices on what is still a very expensive product. Nonetheless, WIC now no longer routinely provides formula to mothers in the first month postpartum; instead, it urges them to give breastfeeding a try, even if for only a few days or weeks. Kathy, a lactation consultant in California, explained the strategy thus:

I just feel like, let’s just not facilitate giving the formula, but explain that [the mother is] actually going to do better if she stays exclusively breastfeeding. Just for the first month. Let’s see how it goes. Come back next month. You may change your mind, and then you can take the formula.

Furthermore, WIC now provides a greater quantity of food to exclusively breastfeeding women, a point counselors use to encourage women to try it out. The program likewise endorses a breastfeeding norm through its mandatory counseling services, providing mothers with prenatal instruction on proper breastfeeding positions, lactation consultants and peer counselors to assist after childbirth, and free breast pump rentals. WIC mothers who do initiate and continue breastfeeding receive lavish praise: women who committed to the norm were often rewarded with small tokens like t-shirts, onesies, and certificates of achievement. In addition, many WIC offices I visited featured a “breastfeeding wall of fame” in their waiting rooms, with snapshots of clients who were exclusively breastfeeding. Such displays were usually featured in a highly visible spot on the wall, where visitors to the office would be sure to see it and, perhaps, to internalize the breastfeeding norms WIC sought to spread. Although counselors could not make mothers breastfeed (or withhold formula), they provided positive reinforcement for breastfeeding, aiming to create a community in which breastfeeding would be valued.

Besides efforts at raising low-income mothers’ breastfeeding initiation and continuation rates to the levels seen among middle-class mothers (a project targeted particularly at African American mothers, who have the lowest rates of any racial/ethnic group), WIC also had changed its food packages recently, in what some counselors described as a long-overdue response to rising rates of obesity in low-income communities. In October 2009, WIC made the first major substantive change in its food packages since the program’s nationwide launch in 1974.⁴ Whereas WIC once aimed to remedy the caloric deficiencies in low-income populations that arose from inadequate food supply, the new program has been updated to counteract the more

⁴ The earliest WIC pilot programs in selected regions began in 1972; the program expanded to cover the whole U.S. in 1974.

common nutritional challenges for poor and working-class families in the 2000s: cheap, calorie-dense, non-nutritious foods. Instead of the eggs, milk, cheese, juice, and infant formula of past years, the program now provides vouchers for whole grains, low-fat milk, beans, peanut butter, and fresh fruits and vegetables (in addition to smaller portions of eggs and cheese). Similar to changes in the food stamp (SNAP) program, many WIC offices and districts—particularly those in agriculture-rich states like California and Florida—are now working to make their vouchers compatible with local farmers’ markets to provide still greater access to fresh fruits and vegetables. As Florida counselor Traci explained, this change is not only about getting food into low-income households; the new food packages are designed to support the lessons nutrition counselors are trying to teach:

A lot of times it’s the parents that don’t want to make the change, not the kid. The kid—at two—is not going to complain that much about drinking one percent instead of whole milk. They might notice the difference, but over time if we can get the kids to drink one percent when they’re two, then they’re going to drink it when they’re 30.

As Traci’s statement indicates, the change from whole milk to low-fat milk had been one of the few major points of contention for mothers as WIC introduced the new food packages; she hoped that the added hassle would pay off down the line when children grew up having cultivated healthier tastes. Mei Mei, working in an office thousands of miles from Traci, reported similar pushback from her clients:

I get a lot of clients saying, “Why am I getting lower fat milk now? I used to be able to get whole milk. I want my whole milk.” And so then it gives me kind of an opening for talking about the calcium content in lower-fat milk, and protein, and saturated fat. So it’s fun to talk about those things.

Rather than simply noting the program’s prerogative to make changes in the food package, Mei Mei had learned to reframe client dissatisfaction as an opportunity for further education. In this way, she exercised the state’s power not to coerce, but to actively shape subjects’ future choices and behaviors. In the sections that follow, I will elaborate the practical and discursive means by which WIC counselors like Mei Mei worked to change clients’ behaviors: (1) framing themselves as possessors of expert knowledge; (2) subjectifying mothers as well-meaning, responsible caregivers (albeit in need of support); and (3) using care to position their advice to mothers as *empowering*, rather than shaming or scolding.

Cultivating Authority and Influence

At both the federal and state levels of administration, WIC endorses a curriculum that teaches women to adopt approved bodily and nutrition practices, such as breastfeeding, mild exercise, and increased consumption of fruits, vegetables, and whole-grain foods. The federal WIC guidelines state, “At the time of certification, *the local agency shall stress the positive, long-term benefits of nutrition education* and encourage the participant to attend and participate in nutrition education activities” (Food and Nutrition Service 2011: 292, emphasis added). State-level materials reinforce that message, with statements like “The WIC Program has been successful because it recognizes the far-reaching implications of proper maternal and early

childhood nutrition...*[It provides] education to influence eating habits for a lifetime*” (Gleason 2001), which links time-limited education programs to lifelong health modification. As both of these excerpts show, the program logic is that nutrition education is an investment for the long term.

Although many WIC-enrolled mothers told me that they took part in the program because of the free food or formula, their continued receipt of benefits was contingent on attending regular nutrition classes or one-on-one counseling sessions with nutritionists. From the point of view of the nutritionists, education was the primary aim of the program, and the voucher booklets for purchasing select healthy foods were tools to reinforce what clients were learning. Indeed, WIC vouchers are designed as only supplemental help for family food budgets, a point that counselors stressed to me. Although WIC food is free, it does not provide everything a household needs for the month, and so families have to make up the difference with their own money. WIC instruction, whether through classes or through the vouchers themselves, may then shape clients’ purchasing choices. Infant formula provides one example of this process: each state negotiates a special discounted rate with a single formula maker, and—unless clients get a doctor’s note that says otherwise—parents are limited to buying only that one brand of formula with their vouchers. This process shapes parents’ purchasing habits, as well as children’s food tastes, such that when parents purchase supplemental formula on their own, they are likely to stick with that brand. More generally, counselors hoped to encourage healthy eating habits that would extend well beyond clients’ short tenure in the program, as when Traci asserted, “If we can get the kids to drink one percent [milk] when they’re two, then they’re going to drink it when they’re 30.”

With this educational mandate in mind, WIC counselors sought ways of bolstering their credibility—and, thus, their success—with clients. The primary source of authority counselors drew upon was medical and scientific knowledge. The counselors I interviewed and observed had a wide variety of educational backgrounds and professional qualifications (ranging from home economists and nutrition educators with a high school diploma to registered dietitians and lactation consultants with bachelors and masters degrees). Nonetheless, all had access to scientific and medical information in the form of WIC’s nationally standardized nutrition curriculum, and they made frequent reference to that information when urging mothers to adopt one health practice over another. When clients occasionally raised questions about differences between what WIC said and what they had been told by doctors or family members, instructors tended to respond by citing the American Academy of Pediatrics and the latest medical research to validate their advice, superseding the more direct authority of family doctors and relatives and imposing the abstract authority of science. Even though medicine was generally held up as the standard for trustworthy health advice, counselors occasionally noted when clients reported getting outdated, incomplete, or misleading advice from their obstetricians and pediatricians, and they sometimes followed up by calling the doctor’s office to investigate.⁵

To a lesser degree, some counselors drew on their own personal success in raising children. Joy frequently mentioned how she had cared for her children and grandchildren. Traci and Mei Mei, neither of whom had children, found other ways to compensate for this lack of personal knowledge: Mei Mei adopted the stance of a well-informed, inquisitive younger sister, validating mothers’ knowledge and expertise while offering advice on issues mothers requested

⁵ This happened most often when a physician deviated from the “breast is best” doctrine and dissuaded women from breastfeeding, or when the doctor allowed non-milk nutrition, such as corn syrup or baby cereal, to be dispensed from the bottle.

help with; Traci, on the other hand, generalized from the experiences of the various mothers she had counseled (thus giving her a big-picture understanding of common issues mothers faced).

Counselors also worked to shore up their authority among clients by placing the WIC-approved foods in the context of regional food traditions. Joy, an African-born nutritionist in her 60s working in California, told her group nutrition class, “Since you live in the Bay Area, with so many different cultures, it is important to keep an open mind.” She urged women in the class to use one of their grain vouchers for something relatively familiar—like corn tortillas or whole wheat bread—and to spend the other voucher on something new. To demonstrate, she walked to the whiteboard and wrote out the recipe for a dish from her home culture that used bulgur wheat (one of the WIC-approved options for the voucher).

It is unclear how many WIC mothers in California actually ate this way, using their vouchers to buy bulgur, wheat germ, tofu, and other such “health” foods allowed under new WIC regulations. In at least one case, a mother—India—told me how her own mother, now on a “health kick,” was more likely to eat those foods and then buy other foods that were more to India’s taste. However, in urging mothers to consume and cook this way, Joy was drawing on the middle-class “foodie” culture of the region, one that values multiculturalism and an extensively varied diet. Even though some mothers lamented the loss of their whole milk and juice vouchers in the updated WIC package, most voiced strong appreciation for the broader range of foods now available to them.

Florida nutritionists likewise sought to encourage clients’ compliance by showing WIC foods’ compatibility with regional cuisines. For example, many of the Florida WIC nutritionists taught about correct portion sizes by taping images of plates to their desks, on the side where clients would come sit. These laminated cut-outs were divided up like pie charts, with half the plate dedicated to vegetables, a quarter to starches (like rice or potatoes), and a quarter to meat. Counselors described this as the “Plate Method,” which they recommended to newly postpartum mothers eager to lose their baby weight, and which would officially replace the Food Pyramid as the Food and Drug Administration’s visual tool for teaching about nutrition in 2011. Clients I spoke to seemed receptive to this approach. Vanessa, a single mother of two children in Florida, told me, “We try to go off that nutrition paper [showing the plate method] that they gave us. We try to do a meat and a vegetable and a bread with every meal.” This view of the complete meal—a meat, a vegetable, and a starch—was described to me repeatedly by mothers in Florida (but not by those in California), and they spoke of learning about it from their own mothers’ cooking. Indeed, the related “meat-and-three” or “blue-plate special” model of eating, which includes a meat-based protein, three vegetable sides, and a starch, has long been a staple of Southern cuisine. Thus, WIC nutritionists in Florida sought to encourage healthy eating in familiar terms, and their authority with clients increased as a result.

Framing Mothers as Adults and Allies

In order for WIC to be successful in driving lifestyle changes among its clients, staff members had to work not only to be seen as legitimate authorities, but also to portray clients—usually mothers—as the ideal subjects of that authority. Emphasizing motherhood as an important component of women’s identities, the WIC curriculum tends to treat women as the default caregivers for children and as centerpieces of their communities; several counselors told me that teaching mothers how to eat (and cook) healthier was the best way to spread their message throughout poor communities. To this end, WIC staff members largely treated mothers as responsible adults, while positioning themselves as empowering allies. Most frequently,

counselors deployed these discursive tactics during their regular, required consultations with mothers.

Of the different services and nutrition education options WIC provides, these one-on-one meetings are the most common. Counseling sessions usually last about 15 minutes, and are required every couple of months in order for mothers (“clients”) to receive new vouchers. Before going into the meeting, the mother completes a form detailing her eating and exercise habits or her child’s. During the meeting, the staff member can refer to this worksheet to target behaviors for improvement.

Generally, given the time constraints of these meetings, staff and clients have to work together to identify their most pressing health and nutrition concerns. Mei Mei, a newly minted WIC counselor in California, described some of the challenges she faces in these sessions, saying: “Even individually, one-on-one, you get a lot of clients that come in here and you can tell that they’re already like, ‘Give me my coupons! I want to leave, I don’t need to talk to you...I already know this. I’ve had five kids’.” In response, she said, she has been trained to use something called motivational interviewing, reflecting the clients’ statements back at them and validating their feelings. For example, to a mother who was impatient to leave so that she could feed her hungry, screaming infant, Mei Mei told me how she responded, saying, “‘Wow, you’re an amazing mom. You’re so concerned about your child, and I love that. And so I’m going to get you out of here fast. I’m going to help you right now.’” She further explained to me, “That relieved her a little bit. You have to be able to read people really well.”

Rather than delivering a 15-minute lecture, several counselors told me that they try to start the conversation by asking what the mother wants to work on this month. Traci explained this to me, saying: “You won’t say it directly, like ‘I want you to change this.’ You’ll say things like ‘Well, how do you think this could be better? What do you think?’ And you’re leading them to that conclusion. And it’s their idea, and then it has more substance to it.” In this way, WIC nutritionists like Traci and Mei Mei pushed their clients to internalize particular body care ideals, inviting mothers to scrutinize themselves and set goals for future changes—in short, to become health-conscious, autonomous, enterprising subjects.

Counselors’ use of these subjectifying strategies became even more noticeable when they addressed weight issues in children. Nearly every counselor I interviewed told me how they used standardized height/weight growth charts to address issues of children’s over- and under-weight with parents. Traci described her typical approach thus:

I usually always talk about the weight, just because I think that they should know. I say, “Alright, so number one on the weight scale, compared to 100 children your age, is the Skinny Mini. Fifty is about average. *That’s where we kind of want everyone, or that’s where most people are.* One hundred is the Chunky Monkey, and your kid is 99.” So I’m not telling them that their child is *fat*. But they’re like “Oh, he’s kind of up there, huh?” And then I say, “Yeah, that’s something we need to work on.”

Of course, the 50th percentile for height/weight growth charts for children actually did not indicate “where most people [were]” in 2010, the year I interviewed Traci.⁶ What the charts did

⁶ The CDC’s height and weight charts for children and adolescents represent a historic snapshot of the population at a particular point in time when the charts were developed, several decades prior to the start of my research (for details, see Flegal, Tabak, and Ogden 2006). As of 2008, 16.9% of all children and adolescents aged 2-19 were in

provide was a set of norms against which clients could measure themselves and their children. As Traci explained, she did not need to harangue parents about their overweight children; rather, she used these charts to display a scientific “truth,” and parents would then fill in the blanks for her. Once a parent had named some problem or health goal to address for the month, Traci and her colleagues could then present themselves as supportive partners in that endeavor. Suzy, a registered dietician and office supervisor in one California WIC office, summarized it thus:

You know, people [here] really are interested and want to do the right thing for their families and their children. You can tell that they really care...In order to be a WIC participant, you really do have to jump through a few hoops to get here. So most of these people really care about their families, and we're making a difference in their lives.

While the number of “hoops” required by WIC was actually smaller than the number required by several other federal aid programs, Suzy’s point was to underscore how the very structure of the program set her up in a cooperative role to her clients.

Thus, a key component of WIC’s approach to subjectifying its clients is in how it enlists them as *allies*, rather than adversaries, and this is an important point of difference from many other welfare programs. Where agencies like TANF have the ability to impose economic sanctions on clients in order to achieve compliance, WIC has only its scientific authority and its relationships with clients. It would be a mistake, however, to assume that WIC has no *power*. Indeed, WIC provides a dramatic case of what Michel Foucault describes as subjectifying power. Contrasting this power to force, violence, or coercion, Foucault argues that subjectification requires “that ‘the other’ (the one over whom power is exercised) be thoroughly recognized and maintained to the very end as a person who acts” (1982: 789). In this way, subjectification (at WIC, and elsewhere) requires acknowledging that someone could choose differently—and that they are free to do so—while shaping them into the kinds of people who will make the “right” choice.

At WIC, this arrangement draws both staff and clients together in the subject formation process. Joy sternly cautioned a class of new mothers: “Listen to your doctor. Grandma is going to tell you something different. Your girlfriends are going to tell you something different. Your spouse will tell you something different. But when it goes badly, who suffers? You and your baby.” In this way, she aligned mothers as being on the same side as WIC and medical authorities, while positioning family, friends, and tradition as obstacles to good health, however well-meaning. Joy and other counselors noted that mothers are usually willing to follow WIC nutrition guidelines, but may face challenges from other household members who do not like the food mothers prepare or who may have other ideas about childrearing. WIC recognizes mothers—and encourages women to recognize themselves—as authorities within their own households, and it notably lacks the punitive elements that other welfare programs use to enforce compliance. Clients largely described their counselors as trustworthy, “like a friend,” and “caring.” I suggest that this dynamic springs, at least in part, from WIC policy. Even though children remain eligible for benefits longer than their mothers, women continue to be the primary interface between WIC and the family. They receive breastfeeding instruction, nutrition education, and tips about how to cook for their families and encourage physical activity. Thus,

the 95th percentile for their age- and sex-specific height/weight range (even though the 95th percentile would seem to indicate that only 5% of the population would fall in that range) (Ogden and Carroll 2010).

while mothers' own bodies are sometimes the target of WIC's efforts (as when they are pregnant or breastfeeding), the primary relationship is one in which WIC teaches mothers how to discipline and nourish their children's bodies, as well as how to enlist partners' and family members' support for those practices, thereby spreading WIC-approved values to their families and communities.

For their part, many women deduced this aim of the program, as 20-year-old India, a Black mother from California, described while talking about the nutrition education.⁷ She told me, "I think all the moms should know [about healthy eating], so that we could teach our kids. I think it's really good." She continued,

[WIC] was telling me, "Don't give her all that juice! Don't give her all that sweet stuff! *You're the parent.*" and all that... but I don't know! You have a kid, and they want something. When I was little, our parents never told us "You can't have that," especially if it was food. You'd always get fed. So it's hard for me to say "No more juice." I don't know. It's difficult.

In urging her to set stricter limits on her daughter's diet, WIC encouraged India to "be a parent." India's reaction to this instruction is interesting, because she notes that her own parents didn't exercise such discipline over her eating as a child. Another California mother, 26-year-old Becky, a White woman, described how her parents—who had grown up even poorer than she—prided themselves on keeping a fully stocked kitchen for their children:

They always had food, and my dad grew up with practically nothing, so he basically filled the house with everything, because he never had anything [when he was] younger. So we had chips. We had tons of stuff that [...] aren't healthy, to eat. So growing up there was a lot of junk food around and sweets, that we were able to—I don't think that my parents gave us free rein to eat *whatever* we wanted, but we did grow up with a lot of that in the house.

For Becky's own parents, and perhaps for India's as well, having an abundance of food around the house was an important family value, a way to show care and provide their children with stability. For WIC, though, "parenthood" would appear to be synonymous with setting limits and managing children's bodies and diets, a norm that is more common among middle-class parents. Such class contradictions show up occasionally in WIC, but WIC program discourses encourage mothers to view them as *generational* differences in childrearing values, rather than *class* differences. Likewise, mothers in WIC often spoke about the program's guidelines as providing the most up-to-the-minute advice for health and childrearing, sometimes contrasting it with the values they were raised with, but their comments on this point focused on health outcomes, not social mobility or class cultural values. With this gentle approach, then, WIC sets itself up as the arbiter of modern, good care, acting not as the paternal figure of the classical welfare state, but as, perhaps, a substitute grandmother.

From that platform, WIC emphasizes the many added responsibilities that motherhood brings, but it also approaches mothers as adults capable of meeting their responsibilities. Twenty-eight-year-old Nicki, a White Californian woman who described herself as normally

⁷ For summary demographics of the mothers I interviewed, see Appendix B.

being a “pretty lousy eater,” told me about how she managed her responsibilities during pregnancy and breastfeeding:

Well, when I’m pregnant I’m feeding someone else. So when I have to make a choice for someone else, I want it to be the best choice. When I have to make a choice for myself, I can live with the consequences. I’m the adult, and I’m the one who has to deal with it. But my kids can’t make that choice for themselves. So I have to make the best choice for them. When I’m pregnant I’m making choices for somebody else, so I want to make the best choice.

As when India was told to “be a parent,” Nicki summed up her role and its relationship to food when she said, simply, “I’m the adult.” This imperative to “be the parent” or “be the adult” through careful monitoring and control of children’s diets, as well as one’s own eating (while pregnant or breastfeeding), forms the basis for the subjectification WIC promotes, and mothers, as we’ve seen, learn to adopt this view themselves.

Choosing Differently: Resistance to Neoliberal Subjectification

When I first began interviewing WIC mothers, I was surprised at the dearth of negative feelings women expressed to me about the program. Most complaints were minor, having to do with specific foods that were or were not included in the vouchers, or with inefficient procedures for rescheduling appointments. Even when women voiced annoyances of this type, they reassured me that they liked the program overall and would not want to lose it. However, a small subset of WIC mothers did articulate a measure of resistance to WIC’s subjectifying processes and health norms, and those moments of resistance or discomfort help illuminate some of the limitations to WIC’s mode of assistance.

As noted earlier, subjectifying power is about influencing—not coercing—people’s choices. As such, the clients of state programs like WIC must be formally free to make choices that WIC does not approve of. Tina, a 41-year-old Black mother of one living in California, explained to me her experience of going against the “WIC Way”:

Not everyone can breastfeed, especially me, at 41 years old. My milk supply was never heavy, and I’m not able...I get what the benefits of [breastfeeding] are, you know? But right now I don’t feel I’m being supported [by WIC] in my decision not to. That’s the only thing I would change about it, that they would be more open-minded and understand that everybody’s situation is different and unique.

Tina was more than a decade older than the average for WIC mothers I interviewed, and she seemed particularly comfortable with the choices she had made for herself and her son. Yet, when WIC counselors tried to educate her about the benefits of breastfeeding, she described feeling “browbeaten” by the experience. In her wish that WIC could be more “open-minded” to the fact that “everybody’s situation is different and unique,” Tina was pointing to the limitations on WIC’s support for mothers’ choices. Though Tina was free to choose formula, she found that WIC was much less flexible than it might initially appear: ultimately, WIC’s aim is not to provide enthusiastic support for mothers with a wide range of parenting and body-care styles, but to shepherd all of its clients toward adopting one uniform health and body norm.

Tina’s strongly articulated dissent was rare in my study, but a number of other clients—particularly those who had been with the program for a while—described having learned how to

edit what they told counselors, either to shorten the length of their visits or to avoid uncomfortable conversations about behaviors they did not plan to change.

Selena, a California mother with twin infant daughters enrolled in WIC, chuckled as she explained this to me. She and her fiancé have enough of a sense of the “WIC Way” of approaching nutrition that they are able to give what they perceive to be the “best” answers on their check-in sheet, rather than the most truthful. Similarly, Paz, a 28-year-old single mother (and a recent Mexican immigrant to California) who had WIC for her four youngest children, told me that she always takes away her 3-year-old son’s pacifier when they go to the WIC office, because she knows that WIC disapproves of bottles and pacifiers for children his age. She defended her use of the pacifier—her family had been through immense turmoil recently following their escape from a domestic violence situation and their temporary stay at a women’s shelter, and the pacifier provided her sensitive son with a feeling of security. When I asked her whether she would ever discuss this at WIC, she shook her head. “I have good relation with some lady there. *Pero* sometimes, I don’t want to tell nothing, because it’s no therapy, it’s only WIC.” Both Selena and Paz insisted that they did value some of the nutritional education that WIC provides, but they had learned ways of directing the conversation towards areas they wanted to cover. These mothers’ strategies for navigating WIC sessions revealed that they had internalized and understood the self-care norms that WIC sought to convey, even though they did not always follow those guidelines. In this way, they gained a measure of external approval for toeing the line on certain childrearing behaviors, while at the same time affording themselves the freedom to evaluate which practices were best suited to their own needs. Indeed, by finding ways to harmonize WIC’s fairly broad recommendations with the demands of their daily lives, these women were not acting so very differently from middle-class mothers (a point I will return to in the next chapter). However, as demonstrated by Paz’ refusal to defend (or even acknowledge) her use of the pacifier to calm her son, saying “It’s no therapy, it’s only WIC,” WIC was not the right venue for asserting an individualized way of doing things; whether due to differing communication styles between staff and clients, limitations of the program’s mandates, or a combination of the two, mothers preferred to avoid confrontations with their counselors.

Even mothers who fully agreed with WIC sometimes found it hard to follow WIC-recommended health practices exactly. 20-year-old Shontel, a Black mother from California, put this most clearly, saying, “They have their questions they have to ask you. Sometimes they just don’t understand, because they want you to do this and they want you to do that, but you don’t always follow everything they say.” Implicit in Shontel’s observation was an acknowledgment of the fundamentally limited flexibility WIC had, as an institution, to accommodate different approaches to health care and mothering, as when she said, “They have their questions they have to ask you.” Although subjectification at WIC requires that clients be able to choose differently—and indeed, Shontel, Paz, Selena, and Tina all did at certain points—their stories show that they were well aware of the one standard for self-care that WIC endorsed, and that WIC’s support for mothers as decision-makers was, at least in part, reliant on mothers making what WIC thought to be the “right” choice. However, despite some reservations, all of these mothers were, on the whole, appreciative of the program’s help, and most sought to align themselves with WIC’s linked ideals of good motherhood and bodily cultivation.

Enacting Gentle Discipline: Creating Subjects, Empowering Citizenship

While WIC’s methods are clearly an instance of subjectification, as the state uses its power to shape individuals and direct their day-to-day choices for their bodies, WIC’s particular

logic is also tied to practices of *citizenship*. Barbara Cruikshank (1999) suggests that the major technique for “constituting citizens out of subjects” is *empowerment*. Specifically, subjects (particularly the poor) may become citizens by developing a personal discipline that they use to change their life circumstances in some fashion (such as getting a job, becoming more knowledgeable about their health, or, generally speaking, becoming more self-sufficient). Critically, empowerment under neoliberal governmentality differs from the type of empowerment historically associated with citizenship: the right to make claims on the government. In the contemporary period, government responsibility has been minimized, and to be empowered is to make changes for oneself. Cruikshank explains,

The tactics for empowerment mobilized in innumerable programs...share a political strategy: to act upon others by getting them to act in their own interest. It is the content of powerless people's interests [and not the strategy] over which the right and the left disagree. (p. 68).

Empowerment does not mean that citizens lead lives free from external control; rather, it becomes both a requirement of citizenship and a tool for shaping the behaviors of subjected populations. Speaking of movements to empower the poor, Cruikshank writes, “The will [of political interests] to empower may be well intentioned, but it is a strategy for constituting and regulating the political subjectivities of the ‘empowered’...Thus ‘empowerment’ is itself a power relationship and one deserving of careful scrutiny” (pp. 68-9).

This element of empowerment, in particular, characterizes WIC’s approach to its clients. WIC undoubtedly disciplines its participants, using record-keeping practices and bodily cultivation to mold clients into the right sort of subjects. Yet, it means something more than bare discipline to the clients and staff; for this reason, I describe WIC’s methods as *gentle* discipline: combining normative oversight with caring empowerment.

Shontel, a young mother who was fond of the program, described it thus:

They always ask you “What are you eating?” They give you a questionnaire when you come in for your appointment. They want to know what’s going on, what your kids are eating, how much are they eating, what are you eating, are they getting enough exercise... They ask questions about your family; *they’re not just giving you food and not caring about your wellbeing and your kids’ wellbeing. They care.* (emphasis added)

Importantly, while the types of information-gathering and oversight typical of WIC’s approach to social aid sound like surveillance, clients report that such attention is not necessarily unwelcome. Twenty-five-year-old Trisha, a White mother of two living in Florida, compared the relative inattention of her children’s pediatrician to the scrutiny she received from her WIC counselor, saying:

The kids go to their regular doctors’ appointments, but they don’t always give you specific tips on how to help them gain weight, help them stay healthier, things like that. And I really like that the nutritionist [at WIC] goes into detail about what you can do. And then another thing I like is, whenever she tells you to do something, at your next appointment she’ll ask you what you’ve done.

Indeed, as Trisha and other mothers explained, they see WIC's brand of surveillance as an indication that WIC is paying attention, that WIC *cares*. That perception holds fast even when counselors' questions seem slightly intrusive; Becky told me, "They are very informative, like when they inspect your children"—and here, she broke off to correct herself—"Well, not *inspect*..." Her self-correction indicated that, while "inspect" might describe how WIC treated her children, the rather clinical word was at odds with the sense of connection she felt with the counselors. The reason I term this system "gentle discipline" is that, when mothers describe their counselors as caring, they are not just being duped into becoming docile clients; in a very real sense, counselors *do* express care.

WIC staff, mainly women and often from the same communities as their clients, act as both authorities and careworkers. Positioned as nutrition experts and bureaucratic civil servants, staff members nevertheless often find themselves having to manage clients' emotions (as well as their own). This is no accident, but actually part of recent developments in WIC policy. In 2010, the National WIC Association partnered with the U.S. Food and Nutrition Service to implement guidelines for Value-Enhanced Nutrition Assessment (VENA). One goal of the program was to create a more positive experience by teaching counselors to be more emotionally responsive to clients. Instead of reading through a list of nutrition questions, VENA instructs staff that "A valuable nutrition assessment is one that facilitates rapport, builds trust, creates an environment for open discussion, prioritizes the participant's personal goals and needs, and truly 'gets to the heart of the matter.' ... [The goal is to create] emotion-based techniques to target participants' underlying motivational drivers – 'pulse-points' - to promote behavior change" (Colchamiro, Mueller, and DiTaranto 2011). Critically, VENA does not allow clients and staff actual flexibility to create personalized nutrition programs (through, for example, altering the contents of the monthly food voucher packages to suit clients' food tastes or cultural backgrounds—at most, the computer system for disbursing vouchers offers a choice between peanut butter and beans, or between regular and soy milk). I witnessed this lack of flexibility firsthand as I sat in on nutritional consultations between clients and counselors, and California dietician Suzy contrasted WIC's directive to individualized, physician-supervised treatment known as therapeutic nutrition, saying, "We can only talk in generalizations. It's all that we're allowed to do." Furthermore, as in the stories of WIC clients like Shontel, Paz, Selena, and Tina from the previous section, it is clear that WIC maintains a relatively narrow and rigid set of norms for approved health and body practices. What VENA *does* do is provide a superficial impression of personalization by eliciting staff members' caring attention to clients, while remaining more or less inflexible in the diet and exercise habits it supports. Many WIC staff I spoke to in 2010 had long incorporated care into their counseling practices intuitively; what VENA did was to explicitly link that care to strategies for modifying clients' behavior.

Mei Mei described to me how care infused her own practice, when she described her reaction to a client who looked as though she had been crying. She said, "I know it's not our responsibility to take care of those issues. They have their own private lives...But I feel bad. As a female to another female, I want to help her." Given that both WIC staff members and clients are predominantly female, the caring that takes place in the WIC office often contains an element of feminine solidarity (as when, for example, staff members described how they hatched a plan to help a client escape her abusive boyfriend by smuggling her and her child out a back door of the office). Opal, a Black clerical worker who managed the referral services at one California WIC office, elaborated even further on the emotional support she was often called on to provide:

The part that's challenging for me is when you have a family that comes and they share their personal information, sometimes their personal history and what they've been through... They want a listening ear to hear why they were kicked out of their housing, why they were kicked off their medical care, or why they are in a domestic violence situation...

She continued,

You know, you are given the resources to help with that, but at the same time, it's an overload on me because it hurts. It hurts to hear people's personal problems and their issues that honestly I can't control, even though I wish I could. I wish I could stop killing. I wish I could create more housing. I wish I could turn back on general assistance and make it longer than three months. I wish I could stop poverty, but at the same time, this is the society that we're dealing with, and you're right now in the community that's most affected... What do I tell myself when I go home and I can't sleep that night because I'm thinking about clients that are here? I'm still trying to find the words.

Engaging with clients' emotional needs, which, as Opal points out, often went well beyond their dietary aspirations, meant that staff found it hard to maintain an insulating professional distance from their clients. Although Traci noted that some WIC staff ended up "jaded," both Opal (a veteran) and Mei Mei (a rookie) spoke of becoming emotionally invested in their clients' wellbeing: Mei Mei "felt bad," and Opal described how much "it hurts." Thus, even though cultivating empathy helped counselors to reach clients—perhaps even to make them more receptive to WIC's health-focused subject formation—that closeness was not without its costs to the staff. As state employees, WIC staff members are tasked with improving health outcomes among the mothers and children under their supervision. But, lacking the coercive power to withhold aid or otherwise penalize noncompliance (a power that is granted to welfare caseworkers), WIC employees instead approach clients as allies (not adversaries), and employ affective care strategies and empowerment tactics to change clients' behaviors. In this way, they exert the gentle discipline on which WIC's success depends, and by which welfare state subjects become neoliberal citizens.

Thus, WIC policy seeks to create subjects who are thrifty, nutrition-savvy, and self-monitoring; as an investment in the future, it focuses these efforts on women who can then spread these values while they care for their children and communities. It does so through a program of deliberately *gentle discipline*, strategically using care and directed empowerment to shape clients into its ideal citizen-subjects.

Conclusion

My research at WIC both extends and challenges the existing welfare state literature in a number of ways. On one hand, the neoliberal shift in the welfare state is apparent at WIC, where benefits are time-limited and relatively frugal, and where the emphasis and rationale for providing aid is education: the "people-changing" function of welfare described by Wacquant (2010), aimed at creating self-monitoring, autonomous subjects. But the day-to-day workings of the WIC office do not match the sternly regulatory images of modern U.S. workfare, nor do they align with the image of the penal state that Wacquant cites as the other institution used to

manage the poor. Rather, WIC represents a different, and perhaps more effective, manifestation of state power.

As *subjects*, WIC mothers are brought under state power as they begin to alter their actions in self-care and health; WIC's subjectifying gentle discipline does not force, but rather, guides mothers to freely choose WIC-endorsed modes of body management. As *citizens*, WIC mothers are targeted with discourses about empowerment via this same gentle discipline. But to what end, exactly, are they being empowered?

In its support for their authority within the home, its acknowledgment of their hard work in caring for their children, and its personalized attention to each woman's situation (however superficial that personalization might be), WIC gives working-class mothers a welcome break from the stigmatizing judgment that is more typically directed at low-income mothers and—in particular—women of color. In this way, it brings these women subjectively and culturally closer to the motherhood experience of the middle class. By emphasizing mothers' authority as adults to set bodily goals and limitations for themselves and their children, it makes maternal caregiving a site of *empowerment* and, thus, of access to citizenship. However, it would be a mistake to think that this approach is aimed simply at making low-income mothers feel better. As Nikolas Rose (2000) explains, "The beauty of empowerment is that it appears to reject the logics of patronizing dependency that infused earlier welfare modes of expertise. Subjects are to do the work on themselves, not in the name of conformity, but to make them free" (p. 334). Rose maintains that the work on the self is what truly matters in this arrangement; the vision of freedom is what motivates and sustains subjects' devotion to that work.

Ultimately, WIC policy is to invest in low-income women's and children's bodies on the basis of a rational, cost-benefit calculation; its future-oriented prediction (and political selling point) that every dollar invested in the program will yield three dollars in savings on WIC children's healthcare is fundamentally neoliberal. Yet, a closer look at this policy reveals a particular set of class expectations: low-income women's and children's bodies are to be trained in self-discipline so that they will not become a drain on the system. Middle- and upper-class mothers engage in many of the same practices with regard to their own bodies and the training of their children's bodies, but the focus differs: here, the goal is to pass on advantage and optimize children's chances of success. It is those aims that my next chapter will address.

CHAPTER THREE

Neoliberal Mothering and the Middle Class: Health, Status, and Self-Identity

In the last chapter, I discussed the ways in which the U.S. state, via WIC, constructs low-income women as health-focused, self-monitoring subjects. It does so by providing supplemental food assistance and oversight while enrolling mothers in a scientifically backed curriculum of dietary and exercise guidelines. I now turn from the formal institutions guiding low-income mothers' care of their bodies and health to the more informal institutions and communities in which middle-class mothers participate. Whereas WIC aims to mold its clients into neoliberal, health-oriented subjects, in this chapter I will explore how middle-class mothers instead experience neoliberalism as expanded choice on the market, unimpeded by government intervention. Absent a unitary set of health and body norms from the state, these women determinedly seek out sources of health advice and support in order to reinforce their sense of their own selves and subjectivities. As such, these women's health pursuits are reminiscent of what Anthony Giddens (1991) describes as "body regimes" aimed at cultivating "self-identity." Diverging from Giddens' schema, however, I will show both how their efforts can be understood within the broader context of neoliberalism and how self-identity formation occurs not just at the individual level, but also through intentional engagement with chosen communities, social structures, and significant Others.

Middle-class mothers in the U.S. are financially ineligible for WIC assistance and other such programs, and so they are rarely required to enroll in formal parenting and nutrition education classes. Thus, in contrast to the mothers in WIC, there is no comparable formal, government-sponsored site of health and body-based subjectification to which middle-class mothers are exposed.⁸ This does not mean, however, that they lack for sources of health and body norms and advice. Just like the lower-income women I studied in WIC, middle-class mothers had much to learn about the bodily processes of pregnancy, childbirth, breastfeeding, and childrearing. Wider societal trends in the West—particularly among educated, middle- and upper-class women—ranging from medically managed pregnancy and childbirth to declining and delayed fertility all mean that these women are now less likely to have personal knowledge of the details of maternal embodiment prior to becoming mothers themselves. These trends separate contemporary mothers from the experience of previous generations, who were more likely to have witnessed home births, been caregivers for younger siblings, and had close family members (mothers, sisters, and extended family) whose pregnancies they could observe. Indeed, a common complaint in my interviews with women across classes was some variant of "Nobody ever told me..." with regard to their bodily experiences during and after pregnancy. Looking at the community and institutional sources of information to which women turned to remedy this ignorance, then, can tell us something important about how women viewed themselves and their body-care habits during the period of maternal embodiment. Whereas mothers in WIC received instruction in maternal embodiment norms via the program's *gentle discipline*, in this chapter I will show how middle-class mothers were inducted into what I call *questing discipline*: the imperative to continually seek new and better ways of caring for oneself and one's children,

⁸ This is one way in which middle-class U.S. mothers' situation differs from that of their counterparts in countries with a national health service, such as the UK.

fueled by status anxieties and demanding the commitment of significant time, energy, and financial resources.

Competing Paradigms: Neoliberalism, Biomedicine, and Late Modernity

Middle-class mothers in my study lived in relatively close proximity to, and under many of the same ideological structures as, the poor and working-class mothers of the previous chapter. As such, their lives were inevitably affected by neoliberal trends in government and in norms for health management. However, a large body of literature suggests that class mediates the experiences of living with a neoliberal state. This classed divergence in experience springs from the underlying structure of neoliberalism itself.

Loïc Wacquant (2012) argues that contemporary neoliberal regimes can be described as “centaur-states.” By this, he means that they present vastly different faces to those at the top of the social hierarchy and those at the bottom:

[The] centaur-state...displays opposite visages at the two ends of the class structure: it is uplifting and ‘liberating’ at the top, where it acts to leverage the resources and expand the life options of the holders of economic and cultural capital; but it is castigatory and restrictive at the bottom, when it comes to managing the populations destabilised by the deepening of inequality and the diffusion of work insecurity and ethnic anxiety. (p. 74)

While WIC calls into question the claim that policies aimed at the poor are universally “castigatory and restrictive” (as shown in the previous chapter), the larger point here is that poverty policy and the welfare state aim to manage the low-income population, even when, as in the case of WIC, the means are sometimes gentle. In contrast, Wacquant argues, the neoliberal “centaur-state” presents to the middle and upper classes a face that is “uplifting and ‘liberating’,” posing the neoliberal drive toward self-improvement and body maintenance as a realm of unlimited opportunity and choice.

The reason for neoliberalism’s appearance as a so-called “centaur-state” is that, as neoliberalism entails the expansion of market behaviors and values into noneconomic spheres of everyday life, self-making projects become tied to consumption. Individuals are obliged to invest in themselves as “enterprising subjects” (Brown 2005; Foucault 2008), but also to make informed choices as “consumer subjects” (Mamo 2010). For those whose financial ability to consume is more limited—in my case, mothers in WIC—neoliberal ideology offers a veneer of empowering choice even as it shepherds subjects toward a unitary standard of autonomous self-care. Women of greater means, however, gain access to a range of choices through their consumption practices. Laura Mamo (2010) writes that, under neoliberalism, all “citizens are self-responsible for the quality, shape, and direction of their own lives, and the role of welfare states and social communities diminishes.” However, individuals’ ability to do so is shaped by class: body-focused “do-it-yourself projects emerge that often require and rely on cultural, social, and economic capital to achieve” (p. 176).

Even as all mothers are held to neoliberal (and gendered) expectations that they will “do it themselves” while managing their bodies appropriately as women and—for their children’s sake—as mothers, class creates important distinctions in how mothers are required to live up to these expectations. In the previous chapter, I quoted California WIC mother Nicki, who explained that her responsibility as a mother and an adult was to “make the best choice” for her health when she was pregnant. A caveat to this statement is that for Nicki and her peers, the “best

choice” is selected out of the possibilities within reach for her (economically, socially, etc.). For middle-class mothers, whose class position creates an expanded range of possible “best choices,” there is an intensification of the social scrutiny surrounding body-care decisions. While less formal than the gentle discipline enacted at WIC, these pressures exert a kind of discipline on middle-class mothers, too, resulting in what I call *questing discipline*. As Mamo suggests, the choices that middle-class mothers confront are “consumer practices [that] call forward not only consumers’ desires and pleasures but also their will to imagine the future: there is no choice but to exercise choice” (p. 175). What, then, are the stakes of these choices? In the sections that follow, I will discuss how mothers’ health and body-care decisions are made in a climate of increased awareness of the risks that follow from making the “wrong” choices, and how such choices also have become increasingly tied up with self-identity formation processes.

Risk and Opportunity

In the Introduction, I described the connections between neoliberalism and biomedicine. As biomedicalization moves from treating “health” as a baseline status to sanctifying it as an elusive goal to be attained, things that could impede one’s efforts at achieving health (in other words, *risk*) must be more closely monitored and avoided. For those with the means to pay, biomedicine also provides an increasing range of treatments for these anticipated risks.

The notion that contemporary life is increasingly oriented around an awareness of risk appears in Anthony Giddens’ (1991) account of “late modernity.” Specifically, he writes that “modernity is a risk culture...the concept of risk becomes fundamental to the way both lay actors and technical specialists organize the world” (p. 3). Giddens’ formulation of “risk culture” as a feature of *modernity* does not fit into theoretical discussions of *neoliberalism* as neatly as does the literature on biomedicalization; however, Giddens’ work is both widely cited and relevant to the experiences of middle-class mothers in this chapter, and so I will briefly chart some of its points of overlap with my broader framework of neoliberalism.

Although the terms neoliberalism and “late modernity” have both been applied to advanced industrial societies at the turn of the twenty-first century—and although they both attempt to explain phenomena relevant to this project such as risk awareness, consumerism, and self-cultivation projects—they are not interchangeable concepts. Some authors, including Wendy Brown, have made the transition from theorizing late modernity (Brown 1995) to instead theorizing neoliberalism (Brown 2005) as the latter gained popularity and theoretical elaboration throughout the 1990s and early 2000s. Still others (Giddens 1991, 1998; Wacquant 2010) persist in arguing for the two concepts’ distinctiveness. For Giddens, first late modernity (1991) and then a “third way” that is neither neoliberalism nor the welfare state (Giddens 1998; Perkins, Nelms, and Smyth 2004) describe the dual trajectories of self and state in the contemporary period. Giddens’ theorization of late modernity emphasizes the continuity between contemporary lifestyles and those of the recent past. In contrast, neoliberalism elaborates on and extends the classical liberal ideals (for individualism and a free market) associated with modernity, but, as it does so, it transforms the roles and responsibilities of the state, the market, and the individual.

In my analysis, I mainly draw on theories of neoliberalism to frame the similarities and differences of women’s experiences across classes, adopting Loïc Wacquant’s (2012) argument that we now see “a novel kind of state that purports to enshrine markets and embrace liberty, but in reality reserves liberalism and its benefits for those at the top while it enforces punitive paternalism upon those at the bottom” (p. 76). In other words, “liberalism and its benefits” refer to the dynamics described by Giddens: the use of self-care techniques to create and sustain a

unique “self-identity” (which I will discuss in the next section). However, where Giddens describes these as universal features of late modernity, I propose that they are available mainly to those with some degree of middle-class material security and educational capital. For middle-class subjects, the neoliberal state acts to enable the sort of self-making projects we associate with late modernity, helping to open up opportunities and choices (indeed, the state appears relatively minimal—its role is to make way for the market). For poor and working-class subjects involved in WIC or any other welfare program, the state is a more constant presence. There, its role is not to step aside, but to step *in*, providing a set of regularized norms and oversight to ensure that its clients become the right sort of citizens: healthy enough to work, self-disciplined enough to monitor themselves for compliance with health and body norms, and knowledgeable enough to pass these norms on to their communities.

Self-Identity and the Body

Giddens’ discussion of a “risk culture” frames people’s expanded awareness of risk as a precondition for modern subject and self formation. He writes, “Lifestyle choice is increasingly important in the constitution of self-identity and daily activity. *Reflexively organized life-planning, which normally presumes consideration of risks as filtered through contact with expert knowledge, becomes a central feature of the structuring of self-identity*” (1991: 5, emphasis added). In this formulation, subjects in the contemporary period have become increasingly preoccupied with constructing and maintaining a coherent sense of self, what Giddens calls “self-identity.” Echoing—but not in conversation with—Judith Butler’s (1990) theory of gender performativity, Giddens argues that self-identity is a self- and socially-constructed *trajectory*, rather than a given: it is “something that has to be routinely created and sustained in the reflexive activities of the individual” (1991: 52).

Critically, the construction of a self-identity involves constant reflection on one’s past, present, and future actions, requiring not only that one act in accordance with an already-existing sense of self, but also that one engage in a process of narrativizing these actions: minimizing inconsistencies in action and revising accounts of the past to help them better correspond to one’s present self-identity. Such self-reflexivity then becomes bound up with the adoption of whole lifestyles and life plans, selected in light of expert opinions on how best to live and with an eye to creating a continuous narrative arc for the self.

In theories of both biomedicine and late modernity, projects of self-identity formation become particularly tied to the care and use of the body. For Giddens, reflexive self-identity work involves a number of practices, including the consumption of self-help books, introspective autobiography writing (through formal memoirs, journals, and—I would add to this list—Internet blogging), and the cultivation of what he calls “body regimes.” These are standardized body management practices, such as routine personal health and hygiene habits, that are conditioned by sociocultural influences, but which also reflect personal tastes. Importantly, by working through the body, these regimes connect personal habits and values to external bodily signs that can be read and interpreted by others (and which may thus act as status markers). Ultimately, while expert advice on health and the body has a role to play, Giddens poses late modern self-care as a question of “developing the body’s ‘own skills.’ Body care means constantly ‘listening to the body,’ both in order to experience fully the benefits of good health and to pick up signs that something might be going wrong” (1991: 102). Thus, body care regimes require constant vigilance against risk alongside self-reflexive analysis of how one’s body feels.

In many ways, biomedical demands on the self are not very different from the body regimes Giddens describes. Under the gaze of biomedicine, “the focus is no longer on illness, disability, and disease as matters of fate, but on health as a matter of ongoing self-transformation” (Clarke et al. 2003: 172). New medical technologies and techniques make the inner workings and health of the body visible, particularly in the case of pregnancy and childbirth (for example, see Haraway 1991; Petchesky 1987). But in addition to formal medical surveillance, the turn to biomedicalization increasingly involves self-surveillance. As Clarke and colleagues write of this development, “Innovations and interventions are not administered only by medical professionals but are also ‘technologies of the self,’ forms of self-governance that people apply to themselves...[thus] creating new biomedicalized subjectivities, identities, and biosocialities—new social forms constructed around and through such new identities” (2003: 165). Thus, for theorists both of late modern self-identity and of biomedicalization, the care of the body acts as an important route to establishing a unique personal identity.

Self-Identity and Stratification

Access to such a wide range of possible identities is, however, highly stratified by class. Clarke and colleagues (2003) note this point, contrasting the rapidly expanding range of elective health treatments to the lack of basic preventative care faced by uninsured and underinsured Americans. They and others further highlight the profits to be made by investing in medical research geared toward diseases of the affluent First World, in contrast to the languishing funding for treating various “Third World” sicknesses. How, then, does “stratified biomedicine” (Clarke et al. 2003) relate to the construction of self-identities through body regimes? Mamo provides one possible answer, emphasizing the role of consumption practices in processes of identity-making: “Consumption serves as the means to ‘make ourselves,’ to achieve a status, an appearance, an identity—a self” (2010: 176). Lacking the means to consume the fruits of biomedical innovation, then, low-income women have a markedly smaller range of tools and techniques with which to “make themselves.”

Giddens nods to this reality, acknowledging, “One might imagine that ‘lifestyle’ refers only to the pursuits of the more affluent groups or classes. The poor are more or less completely excluded from the possibility of making lifestyle choices” because of their economic disadvantage (1991: 5). However, his larger argument is that the dynamics of late modernity and, in particular, self-identity formation, apply to everyone; even the limited choices of poor and working-class subjects should be treated as evidence of contributions to ongoing self-identity projects. In the current study, I have some sympathy with his claim: acknowledging even limited choices (rather than proclaiming an absence of all agency) among those facing constrained circumstances usually provides for a richer picture of social action and inequality, and it is a theme to which I will return in the next chapter. However, in this chapter I depart from Giddens’ theory in two major ways. First, my findings suggest that the mobilization of health and body-care habits en route to developing a coherent self-identity is expressed very differently depending on class position and resources. In particular, it is *middle-class* mothers, rather than all mothers, who have the resources and time to engage in the full range of self-identity practices Giddens describes (in particular, the complementary processes of self-narrativization—the elaborate stories they tell about their choices and their journeys—and the practices they adopt in line with those narratives). Far from being a universal process, the mobilization of maternal embodiment practices to support self-identity formation is distinctly middle-class, requiring both significant material resources and the cultural knowledge with which to channel them toward the

“best” health and body-care projects as part of a broader healthy *lifestyle*. Second, self-identity is not, as Giddens implies, an individual enterprise. Middle-class mothers embarked on this project by cultivating their practices within a community of peers and, critically, constructing negative and positive reference groups against whom they measured their choices or to whom they turned for advice.

Subjects

Middle-class mothers in my study were demographically distinct from the low-income women from the previous chapter. Of the 36 middle-class mothers I interviewed, 35 were married at the time of our interview, and the one outlier was, nonetheless, living with the father of her children in a long-term relationship comparable to marriage. Thus, these women’s households benefited either by having two adult incomes or by giving mothers the option of staying home with their young children (22% of California mothers and 56% of Florida mothers; none of the women I interviewed had stay-at-home husbands). Average household incomes in this group were upwards of \$116,000 a year (with California household incomes tending to fall well above those in Florida, likely due both to California mothers’ greater likelihood of working and to higher incomes and costs of living in the Bay Area). Middle-class women in my study were also extremely well educated: in both California and Florida, 89% of the women I interviewed had completed college or, for the vast majority, graduate or professional school.

These women’s childbearing patterns were fairly typical of middle-class U.S. women in the 2000s. The average age at which middle-class women in my study had their first child was about 31 years (as compared to the national average of about 25 years in 2006 [Mathews and Hamilton 2009]), in line with trends in delayed childbearing among women with college educations or higher (Brand and Davis 2011; Edwards 2002; Mathews and Ventura 1997; Rindfuss, Morgan, and Offutt 1996). Furthermore, although most of these women were in the midst of their childbearing years and could, conceivably, still have more children if they so desired, at the time of our interviews they had an average of 1.5 children, similar to national averages for college-educated women (Mathews and Ventura 1997). Finally, in terms of racial and ethnic backgrounds, 78% of California mothers and 94% of Florida mothers in my study described themselves as White or Caucasian (31 total). The remaining five women identified as Hispanic/Latina (2), biracial (2), and East Asian (1). I should note, however, that while I did not ask about their partners’ or children’s racial/ethnic backgrounds, about a quarter of the middle-class women in my study volunteered that their children were biracial. As such, many of the women who experienced privilege due to their racial/ethnic background may, nonetheless, have had elevated awareness of racial and ethnic dynamics on their children’s behalf.

Body Care and the Maintenance of a Coherent Self-Concept

In the sections that follow, I will first describe how women thought about the relationships between their body-care practices, values, and self-identities. Going beyond Giddens’ largely individual-focused analysis, however, I will then show how these beliefs worked in concert with particular social structures (women’s chosen communities and sources of health advice and information) to produce a coherent and stable sense of self.

Food and Diet

Obviously, women’s experiences of becoming pregnant, giving birth, and learning to mother involve change, both physical and mental/emotional. Mothers’ bodies are reshaped, from

the inside out, so that they can support life both during pregnancy and after childbirth. The hormonal shifts that many mothers experience during this time can cause new physical and emotional sensations, both positive (for example, increased sensuality at various points in the cycle) and negative (such as postpartum depression). Additionally, pregnancy and the arrival of a child can alter mothers' relationships with partners, other family members, and employers. And, to be sure, many women I interviewed spoke about these changes.

Among middle-class women, however, one of the strongest themes that emerged inductively from my interview data was that of constancy: in women's habits and practices of caring for themselves, and in their longstanding sense of self-identity and moral commitments. This finding complements the work of Lucy Bailey (1999), who examined first-time pregnancy as an opportunity for changes in self-concept, but found, rather, the theme of an augmented—but consistent—identity (terming this phenomenon the “refracted self”). In the course of describing how they cared for their bodies during and after pregnancy, several of the middle-class women I interviewed made reference to their self-care regimens prior to becoming mothers. For these women, most of whom came from middle- and upper-class family backgrounds, pregnancy was not the first time they had confronted norms for the care and cultivation of their bodies. Rather, the notion of a modifiable, trainable body was familiar from other parts of their lives. Stephanie, a White, 32-year-old Californian mother of two, explained that her attempts to eat healthily during pregnancy were made easier by the fact that her diet was already low on processed foods. She explained her mindset when she became pregnant for the first time:

With Jackie, I wanted to have the absolute perfect pregnancy, because I wanted her to have the best start in life. And so it was like, “OK, I need to eat fish twice a week. And I need to eat this, and that.” And I've always had a diet that's very low in processed foods. I've always had a diet that's very low in junk. I've never been an empty calorie person. But I was much more aware of what I was eating because I was eating for a purpose.

Stephanie's comments reflect her belief that a “perfect” pregnancy was within reach for her, given her preexisting body-care knowledge and routines. Pregnancy did not require her to become a different kind of person or to adopt radically new habits; rather, it elevated her current practices to a higher moral purpose. Florida mother Joan, a White 38-year-old, also emphasized consistent food values, tying them to her own childhood and saying, “I think that good nutrition is really important, and over the years I've just learned more, like about the high fructose corn syrup and the hydrogenated oils, and eating organic. So we do that. And I learned about it from my mom.” Thus, Joan built up her knowledge about nutrition over time, but grounded it in the teachings she received during her early years. Finally, Charlotte, a biracial 32-year-old living in California, told me how pregnancy required greater consciousness of what she ate, but few changes in her actual eating habits: “[During pregnancy] I paid a lot more attention to what I was eating. I think I've always eaten well, a balanced diet, but I haven't ever really given it that much thought. I think I've just had good eating habits.” Indeed, many of the middle-class women I interviewed had stories similar to those of Charlotte, Joan, and Stephanie: their eating and exercise habits prior to and during pregnancy differed mainly in terms of degree (e.g., in the intensity or care with which they monitored themselves) rather than of kind (adopting a wholly different attitude or approach to the body). Worth noting here is that these mothers may well have selectively edited their accounts of past health care habits in order to present a more

coherent narrative of themselves and their values. As Giddens (1991) would say, though, this is to be expected as part of a larger project of self-making, in which both coherent self-narratives and attentive body care play a role.

Indeed, these emphases on behavioral continuities between mothers' pre- and post-baby self-care regimens were about more than just habits; for the middle-class women I interviewed, they represented a way of being—an identity. With her statement about not being an “empty calorie person,” Stephanie tied her body-care practices to her sense of self. In her choice of wording, Stephanie described herself as being a specific *type* of person: avoiding empty calories wasn't merely something she *did*, it was who she *was*. One implication of this style of self-presentation is that there are, then, different types of mothers: those like oneself, and those who are different. Stephanie underlined this meaning a short while later in our conversation. She told me how she'd planned and prepared for birth, saying, “Despite the fact that since the dawn of time, people have been giving birth, now there's a right way to do it and a wrong way to do it. And I'm definitely a *right way-oriented person*, so I wanted to figure out the right way to do it” (emphasis added). This remark signals Stephanie's understanding that she lives in a time of greater risk awareness, such that every decision presents both an opportunity to do things the “right” way and a risk of doing them “wrong.” Furthermore, even though Stephanie's comment suggests a degree of skepticism about the validity of “right” and “wrong” ways of giving birth by reference to the fact that women were giving birth long before modern medical expertise intervened, the corollary to her claiming an identity of being a “right way-oriented person” is that there must also be “wrong way” *types* of mothers. As I will describe in later sections, this pattern of self-identifying as a particular type of mother is critical for many women when they seek out or reject others as reference groups and sources of support.

Thirty-eight-year-old Kirsten, a White California mother currently pregnant with her third child, suggested that particular food and body care habits align not just with personal tastes, but with entirely different types of people: “I've found that people's food practices are so different than mine! ... Like, I was never into chips and things like that, but some people are chip people.” Kirsten had studied nutrition and food science in college, and she expressed shock at what some people considered “food.” And Fiona, a White, 39-year-old from California, contrasted her own “type” with that of her husband, saying, “I'm just not somebody that's into extremes, in any way. I've never been the type of person that would sit down and eat a whole bag of potato chips or cookies.” Fiona's reference to “extremes” serves to frame her own identity as based on balance, moderation, and control, another common theme among mothers in my study (and to which I will return in the final section). Furthermore, to be the “type” of person who could eat an entire bag of chips in one sitting seems almost an indictment of one's character, not just an action one takes.

Lee was one woman who might have fit Stephanie's category of an “empty calorie person” or Kirsten's image of a “chip person.” An upwardly mobile Californian, White 30-year-old mother of one, Lee said, “I am a person that... before I was pregnant I was like, ‘Give me a bag of Doritos and a Coke and I am good to go!’ Still do, frankly...[but now] I use a lot of willpower. I don't need that.” She described her endeavor to feed her daughter fruits and vegetables, which conflicted with her description of herself and her husband as “carb people.” Thus, Lee framed herself as one “type” of person—a Doritos-and-Coke craving “carb person”—who nevertheless fought her natural cravings with “a lot of willpower.” Lee's discussion of her own dietary preferences differed from those of Stephanie, Kirsten, and Fiona in that she focused on the role of self-control—“willpower”—in fighting unhealthy cravings. In a broader sense, though, Lee's

story actually reinforces the underlying belief that these other women shared: namely, that food and eating tastes are so physiologically or socially relevant that they now constitute one facet of these women's identities. Furthermore, unlike Giddens' theorization of self-identity processes, their behavior-based self-identities were bolstered by references to implicit, out-of-control Others, over whom these women appeared morally superior.

Exercise

Although not nearly as widespread as women's comments about belonging to various food-oriented types, a substantial minority of my respondents also emphasized a passionate identification with exercise and athletics. With an average age of 33.7 in the years of my study (2010-11), women I interviewed were mainly born in the mid-late 1970s. As a point of reference, Title IX, part of federal regulations requiring equal opportunities for men and women in education (including interscholastic athletics), was passed in 1972. Thus, most of the mothers in my study came of age at a time when women were increasingly supported in joining competitive sports, pursuing athletic scholarships, and otherwise incorporating athleticism into their personal and professional lives. For many of my subjects, then, managing an "athletic self" became an additional issue to juggle when they became pregnant. Misty, a White 31-year-old from California, described how she faced particular challenges in dealing with the body changes of pregnancy, especially when she had begun to gain weight but did not yet look pregnant. She told me, "I've always been fit. I've always had a pretty healthy body, having been a swimmer. So that was difficult. But when I was showing [i.e., visibly pregnant], it was fun." Interestingly, Misty later told me that she had continued regular jogging into her eighth month of pregnancy; underlying her comments about fitness during pregnancy, then, was a concern not with her activity level, but with her slim appearance of *looking* fit. In a different vein, 35-year-old Suzanne, a White mother from California, connected her expectations for pregnancy to her preexisting athleticism. She told me, "Because I was such a strong athlete I was like, 'Of course I'm going to have natural childbirth.' My mom had natural childbirth and she's very fit. So there's something about athleticism and natural childbirth that I thought went hand-in-hand." For Suzanne, her inability to deliver her child without medical intervention felt like an indictment of her tough, athletic, pain-tolerant self. Fiona expressed a nearly identical sentiment about her eventual Caesarian section, saying, "[Childbirth is] something that I always thought women could get through, and I've done triathlons, so I was like, 'I can handle this.' So, [having the C-section] was a little disappointing." Although Fiona's and Suzanne's childbirth experiences represented, to them, a failure to maintain a coherent, athletic self-identity while becoming mothers, a key point in these stories is that, once again, exercise was a significant component of their self-concept; their so-called "failures" were particularly disappointing not because they negatively affected the health of the child but because they disrupted the women's stable sense of self and bodily control.

Work and Personality

Finally, one of the biggest challenges to women's construction and maintenance of a coherent self during the transition to motherhood was the loss or devaluation of career-based identities. Sociologists have often noted that motherhood, for women, tends to act as a *master status*, overriding other aspects of self-identity and social status to become the most salient feature of an individual (Hughes 1945; Levy, Widmer, and Kellerhals 2002). Most of the middle-class women I interviewed resisted this phenomenon, a struggle that was made more difficult by

the fact that most women in my study experienced some interruption in their work schedules after having children, whether opting to stay home to care for children full-time or scaling back or otherwise altering their work commitments, such as through negotiating for more flexibility to stay at home or moving into self-employed consulting work. Many have speculated about a potential crisis of identity that unemployed men might face during periods of economic recession (Waters and Moore 2002; Wood 2012). However, my research suggests that middle-class women, too, experience serious challenges to identity when they weather even temporary and anticipated interruptions in their professional careers. These women tried, with varying degrees of success, to translate their work-based personae and skills to meet the requirements of motherhood.

Thirty-five-year-old Amy, a Chinese-American mother of two living in California, put this identity crisis most bluntly when she described her transition to becoming a full-time stay-at-home mother. Following the birth of her first child, Amy returned to work in her corporate job full time, but had to change her plans when her son became seriously ill with a virus he caught at his daycare center. She explained how drastically she had to readjust her expectations and sense of self, saying, “At first I never thought that I could be a stay-at-home mom...I know it’s busy, still, but the thought never crossed my mind. But I think it was when Alex got sick a *lot*, it kind of made me prioritize things. [But] prior to my son being born I always thought, ‘I’m going, I’m working. There’s no way I’m not going to work.’” Amy further explained to me that this experience was common among the high-powered women in her social circle. Reflecting on the story of one of her friends, she told me, “It’s hard to leave something you’ve worked so hard for. And [my friend] spent \$120,000 on law school and developed this career and she left it because of her children. That’s something remarkable. To give that up is a big part of her personality. She’s still a pretty Type A personality, and she runs her household like that.” Although Amy did not, herself, identify as a “Type A personality,” this self-descriptor was common among women in my study, and it was one of the primary facets of identity with which many attempted to translate between what was required of them at work and at home. Cass, a White, 33-year-old first-time Florida mother, said, “I have a big perfectionist streak which has served me well in all my jobs and other facets of my life, but it does not serve you well when you become a mother, because you just expect way too much from yourself.” Lee, too, applied her achievement-oriented personality to her mothering when she ran into difficulties breastfeeding:

There was no *rational* reason why I felt so bad about [having those problems], but I think it was my reaction to that burden: “I have to do this, and no one else can do it. I have to make it work.” And I’m so Type A. I had that goal of [breastfeeding for] one year, and I’m like, “I will make it to that goal if it kills me!”

In a near-perfect illustration of Giddens’ account of self-identity formation, Lee thus described herself as being of a particular type (“Type A”) and as having set particular goals that bolstered that identity. Yet, while Lee’s “Type A” tendencies led her to set goals for good mothering habits, she also suspected part of her difficulties with breastfeeding might have arisen from her stress over meeting a self-imposed benchmark. Thus, both she and Cass expressed serious reservations about the extent to which a “perfectionist,” “Type A” personality was compatible with being an effective mother.

Many of these issues came into play for Greta, a White, 40-year-old mother from California. Greta, a mother of two, had resigned from her position as an oceanographic

researcher to stay at home full-time with her children. Although she did not say that she regretted this choice, her comments to me indicated that she had struggled to reconcile her identity as a mother with her more established identity as a scientist: “I find that I’m the one that’s doing almost all the parenting, which is hard. I’ve had a job—I was a research oceanographer—so it’s hard to go from working and having colleagues and being a professional to then parenting small children.” At times, Greta found that her work identity reasserted itself as she educated herself on how to care for her children. When she mused that her constant reading about pregnancy and childbirth might have caused her to have rigid, stress-inducing expectations about those experiences, I asked whether she wished she had done anything differently. She responded that she couldn’t have done things differently, because of who she *was*: “I don’t think you can [avoid building up your expectations], because you read, and that’s what I’m programmed to do—I’m an oceanographer. I read. I try to solve a problem. And I go to my literature, and I go to the Internet, and that’s how I deal with life.” Although Greta had left her job some time ago, her continued identification as an oceanographer showed its centrality in her sense of self and in her approaches to parenting. The context in which she deployed her hard-won skills had changed, but their importance to her self-identity remained clear.

Overall, a large number of middle-class women I spoke to highlighted the ways in which their longstanding identities as conscientious eaters, tough athletes, and/or trained professionals related to their new, maternal selves. Even at times when embodied experiences of motherhood forced them to adjust their expectations (as when an athletic mother was unable to have an “all-natural” childbirth or when a professionally-identified woman opted to stay at home with her children), mothers in my study nevertheless used those preexisting identities to explain some of their feelings about motherhood and to construct consistent narrative arcs for themselves. This enduring sense of self voiced by so many middle-class mothers not only helped them make sense of their past experiences and feelings but also led them to make particular choices about self-care, parenting, and the people they looked to for advice. It is to these choices that I now turn.

Disciplining Middle-Class Women: Motherhood as a Quest

One of the major points of difference between mothers enrolled in WIC and the middle-class, non-WIC mothers I studied was that while WIC mothers were gently disciplined to subscribe to one, state-approved set of norms for health and body care, middle-class mothers drew their practices from a virtual smorgasbord of options (including conventional Western medical care, acupuncture, homeopathic and herbal remedies, and nutraceuticals—or, “functional foods”⁹), largely made possible by their financial resources and their resultant ability to experiment with various preventative treatments. An obvious explanation for this difference is that WIC mothers all had in common their participation in WIC, a program with a relatively centralized national curriculum, while non-WIC mothers lacked that unified source of instruction.

However, comments from some women in WIC who were college-educated and/or had middle-class family backgrounds suggest that the mere presence or absence of participation in

⁹ Nutraceuticals, or what Doris Schroeder (2007) calls “functional foods,” are foods believed to have naturally-occurring health benefits. According to Schroeder, “in addition to the bulk ingredients and calories that one consumes when eating a food, a functional food has to deliver an additional beneficial effect on health or well-being” (2007: 248). While, as Schroeder notes, the benefits of supposed functional foods are sometimes dubious, the women I interviewed extolled the virtues of vegetarian diets, gluten-free diets, “whole foods” (as opposed to processed foods), and other dietary regimens they believed contributed to their own health and wellness or those of their families.

WIC is not enough to explain this difference: these financially lower-class, culturally middle-class women were more likely to cite alternative sources of health knowledge or to describe the WIC curriculum as “basic” or “simple,” thus indicating that part of their middle-class cultural and educational capital included a greater awareness of—and access to—multiple norms for health and wellness. Middle-class women in my study approached body-care information and expertise as informed consumers, usually neither discounting doctors’ and family members’ advice nor accepting it wholly and uncritically (thus illustrating Giddens’ argument that contemporary self-care requires not only engagement with expert advice but also, first and foremost, a sense of ultimate responsibility for one’s own health). Alongside standard medical guidelines for prenatal care, middle-class mothers also researched alternative treatments and ways of navigating potential health conditions.

All told, the peer and societal pressures on middle-class mothers to pursue the best self- and child-cultivation practices contributed to what I call *questing discipline*. Whereas gentle discipline is a specific technique cultivated at WIC in order to make low-income women more receptive to the program’s unified health and body norms, questing discipline acts on middle-class women to keep them perpetually searching for the next new thing. Women in WIC who were culturally middle class, for example, were dissatisfied with—or at least skeptical of—the relatively straightforward prescriptions for health offered by the program. With a keen awareness of ongoing biomedical advances, sharpened by conversations with peers and healthcare providers, middle-class women came to view successful motherhood, self-care, and self-identity as a *quest*: the ongoing pursuit of a sacred goal (such as child wellbeing or self-identity), wherein the seeker shows herself to be worthy of that goal through her perseverance in the face of challenges. This orientation in turn disciplines mothers’ choices, impelling them toward a perpetual striving. Finally, unlike the clear structure of authority in WIC, where gentle discipline was exercised by government employees, questing discipline works through the very peers and communities that middle-class mothers seek out, thereby illustrating Foucault’s observation that disciplinary power “is not exercised simply as an obligation or a prohibition on those who ‘do not have it’; it invests them, is transmitted by them and through them” ([1975]1995): 27). It is to those chosen sources of support—and discipline—that I now turn.

Reference Groups and Support: New Challenges to Maintaining Self-Identity

The health-management approaches mothers sought out, and the various individuals they turned to for support in making those decisions, were aimed not only at maximizing mothers’ and children’s health, but also at upholding and re-stabilizing mothers’ preexisting sense of self.

A Mother’s Best Friend: Like-Minded Peers

Beyond all other sources of advice and support, middle-class women in my study most frequently turned to their peers: other mothers who tended to be of comparable age, education, and class background. Many women emphasized the importance of having friends and confidantes who shared compatible parenting approaches and value systems to one’s own. I spoke to Louise, a White, 37-year-old Florida mother of two, about her body care values, and asked her to describe someone she knew whose values differed from her own. She responded, “I tend to be around people who think similarly about things as I do, so I can’t think of anybody who’s like that.” Likewise, Charlotte explained to me that she’d most trust her friend Aileen for advice about health issues. I asked why, and she responded, “Because we have the same approach to eating and to life. So I would ask her, probably expecting to get back an answer that

I would already have come up with.” I inquired why that would be important to her, and Charlotte said, “To confirm what I was thinking. Sometimes I bounce things off her, hoping to hear what I already think. And when I don’t, it makes me rethink what I was thinking.” For Charlotte, constructive criticism or disagreement with her chosen approach to her health and body would only be welcome from someone with essentially similar values. While drawn-out discussions of health and body choices among mothers form an important part of their self-narrativizing projects, it would seem that they can achieve this goal only within a context where the participants have a shared base of knowledge and values. Furthermore, the implicit subtext to Charlotte’s statement was that mothers are subject to unwanted criticism on a number of fronts; as many women of all classes told me, the healthiest way to deal with such criticisms was generally to ignore them. Misty made this point even more clearly, explaining to me that surrounding herself with like-minded friends and readings was also a way her to preserve her sanity: “I think you have to find the resources that are aligned with your position, or else it will only add to your guilt.” Misty mentioned “guilt” a number of times in her interview, often when discussing how she had failed to live up to some medical norm for maternal embodiment (such as when morning sickness kept her from taking prenatal vitamins, and she substituted the more palatable *Flintstones* vitamins as a compromise). Indeed, it would seem that the expanding number of options for prenatal care and cultivation, not to mention for child health and nutrition after childbirth, carry the potential downside of making women feel that for every choice they do make, they are at risk for what Misty called “mom guilt” for not attempting some other approach—the “culture of risk” that Giddens (1991) describes. Furthermore, this guilt reflects and reproduces the questing discipline to which middle-class mothers submit. Individual invocations of so-called “mom guilt” reflect mothers’ worries that they are not doing enough and, when voiced in communal spaces such as “mommy groups,” may contribute to other women’s anxieties as well, thereby reinforcing the notion of good motherhood as a neverending quest.

Misty’s comment about finding resources “that are aligned with your position” also indicated her belief that mothers already will *have* a position—on body care values, food and diet, exercise, etc.—and that they will seek to act in accordance with that position. Far from being blank slates upon which new knowledge is written, mothers narrate their choices about self-care during the maternal embodiment period in light of their preexisting values and self-concepts, all of which influence their choices. Bree, a White, 33-year-old California mother, explained how important these factors were when choosing her friends:

I have a lot of good girlfriends, a good social network of moms. They are right in it with me. They are not super athletes, but we’re good athletes. We’re strong. We’ve come a long way. A lot of them have had two kids or three kids. We value identity outside of being a mom.

Thus, even while Bree sought out friends who shared the experience of being mothers, she emphasized the importance of other aspects of identity besides motherhood. Similarly, Amy told me that she felt particularly drawn to friends who valued the active, exercise-intensive lifestyle she prioritized. She described this orientation to her body, saying, “I always took care of my body, so I never wanted to let myself go, for any reason. Some people do; I just didn’t want to. It was something I believed in.” She continued, “The moms that I try to keep friends with coincide with the lifestyle that I like.” For Amy, finding friends who shared her attitudes toward food, exercise, health, and self-control was a way of bolstering her own commitment to not “letting

herself go” following childbirth, and to maintaining a consistent sense of self (a self that might feel more unstable when, after the birth of a child, fewer things appeared to be under her control). And Stephanie, while taking a more relaxed approach to her post-baby body than Amy, voiced similar feelings about the importance of like-minded peers when describing one of her close friends: “Cheryl and I just seem to have a lot of common experiences, which is really nice. It was a relief that somebody else felt that way, where it was like, ‘I don’t care if I look like this the rest of my life now.’” Stephanie noted how images of svelte TV mothers could make a woman feel bad about herself if her body didn’t “bounce back” to its pre-baby shape and size, and felt that having a comrade with whom to discuss the realities of mothers’ post-baby bodies was helpful for resisting such controlling images; although she was confident in her self-identity, she cemented it by co-constructing a particular narrative with her like-minded friend.

Peer-Group Institutions: The Ubiquitous “Mommy Group”

For some women, finding these like-minded peers to support their decisions and reinforce their sense of self happened easily, as when multiple friends in a social circle became pregnant around the same time. For many mothers, though, such networks did not exist, and so they worked to build or join intentional mothering communities—“mommy groups.” Not all peer networks consisted of equally strong ties. At minimum, most women in my study subscribed to one or more mothering websites or electronic listserves, where they could post questions on a range of topics or provide answers to other women’s queries. Participation in such diffuse networks offered mothers the benefit of a wide range of opinions and recommendations; at the same time, many women took part in those conversations only passively, reading other members’ comments but never offering their own input. Additionally, Louise’s experience with her local mothering listserve demonstrated the limits of the closeness she could achieve through an online community. Louise had been a faithful reader of the group’s message boards, and decided to attend an in-person event sponsored by the group.

We went to one of their events at Easter time this year ... And basically everybody ignored us. It felt bad...It was a waste of our time, and I don’t want my daughters to feel like they’re being shunned, you know? Maybe if we spent more time with these people they would be a little warmer. But it seemed like they already kind of knew each other and we were the new people and [their attitude was] “We don’t want to know you.” Nobody made an effort to know us. Nobody said hi or anything, so we just said, “Forget it. We’re not going to do that.”

Louise tied her feelings around this event to similar experiences she had as a child, when her rural, farming background set her apart from her town-dwelling classmates (an association suggesting that Louise sensed that her shunning might be partially class-based). Furthermore, for Louise, finding herself and her children snubbed by women at the event was a rude awakening, given the intimate details and support that the same women shared online. Indeed, other women noted to me that what made online support groups work was, precisely, their anonymity; that type of closeness did not necessarily translate well into in-person familiarity.

Many women found their peer reference groups, then, by joining activities geared toward new mothers. Explained Stephanie, “I had built a huge network of friends with their first babies. And several were starting to have their second babies. I joined a mothers’ group after Jackie was born—for first-time moms—and there were twelve of us in the group. And nine of us have

remained very close.” In some cases, women found their mommy groups with help from the hospital where they delivered; Florida mothers Cass and Emily, whom I interviewed together, had met and become friends through a postpartum depression support group organized by their medical provider. Still other women formed communities once they enrolled their children in daycare together (as in the case of Lee) or joined postpartum exercise classes (as happened for Suzanne, Bree, and Greta). Prenatal yoga classes and breastfeeding support groups like La Leche League were also common sources of community. What made many of these activity-based communities particularly strong, I argue, is that they enabled women to connect on the basis of shared values, interests, or identities beyond simply becoming mothers. In other words, not just any group of mothers would do as a source of support; women sought out particular groups that validated their personal ideals and identities including—but not limited to—motherhood. As Bree noted in the previous section, she had cultivated friendships with women who “value identity outside of being a mom.”

Thus, while middle-class women in my study did not join formal, government-sponsored classes on parenting, they nevertheless sought out and participated in informal institutions in the form of mommy groups. Such groups enabled them to connect with similarly-situated peers who, particularly in the case of in-person, activity-based groups, shared mothers’ values and priorities for health and childrearing. Additionally, given that many groups were based in particular neighborhoods and communities, and that some cost money to join (as in the case of mothers’ exercise groups), women were also likely to meet peers who shared their economic and/or educational position, as well as, in many cases, racial/ethnic background. In this way, mothers’ groups offered emotional support and norm reinforcement, disciplining and bolstering middle-class women’s ongoing commitment to a shared quest.

As I have shown in this section, middle-class women often built or sought out informal mothering institutions that connected them to support and advice from same-generation female peers. Yet, what of the other, traditional sources of support that these women might draw on, particularly the institutions of family and marriage? In the sections that follow, I will explore women’s attitudes toward relying on help from their own mothers, as well as from their husbands.

Generational Differences: Does Mother’s Mother Know Best?

Traditionally speaking, grandmothers have often been the primary sources of information and assistance for new mothers. Yet, many women in my study explicitly distanced themselves from their own mothers. Stephanie told me about how, living in the Bay Area, she was the first woman in her group of friends to have a baby (at age 28). As a result, she had few peers with whom to discuss the changes that pregnancy brought. She said, “I just knew no one who had had a baby in thirty years! And you know, there’s all these common experiences, every woman goes through it. But it’s a lot harder to talk to someone in your mother’s generation about the changes that are going on than it is to talk to somebody your own generation.” Amy clearly explained to me why she preferred friends’ advice to her own mother’s, saying, “[I would ask] a lot of my girlfriends. They are most all moms by now. I don’t talk to my mom as much, because she comes from a very different background and lifestyle.” Elaborating on their different backgrounds, she told me how her mother believed in using traditional Chinese herbal and homeopathic medicines, while Amy—married to a physician—preferred Western medicine. This mother-daughter difference actually reverses the dynamic that many other women told me about, in which European-American mothers favored Western medicine, while the daughters sought out alternative treatments. 31-year-old Emily, a White mother from Florida, was one such woman.

Emily disapproved of what she perceived to be her own mother's overreliance on Western pharmaceuticals:

I don't want to end up like my mom. And she's on a million medications. And her first reaction when I'll complain about something is, "Oh, you should take such-and-such a pill." Well, [sighing] I don't like that to be my first line of defense. So when I had some major health problems four years ago, she kept trying to get me on medication. "Oh, well this helped so-and-so. And this one helped so-and-so." And I was like, "You know what? I think I'm going to try acupuncture."

As these two stories from Amy and Emily show, the substance of mothers' and daughters' disagreements was often less important than the fact that these women did not perceive their mothers to be reliable, legitimate sources of knowledge about health and bodies. Interestingly, the distrustful attitudes toward previous generations' wisdom that middle-class mothers like Amy and Emily voiced are very similar to the attitudes I describe in the previous chapter as being encouraged and cultivated by WIC in its clients. They also highlight the ways in which, living in a "risk society," good mothers must rely not on "timeless" traditional wisdom but on the knowledge and advice of experts.

In some cases, such as the ones above, mothers' and daughters' differences centered on their divergent personal philosophies on health and medicine. In other cases, daughters rejected what they perceived to be their mothers' over-identification with the bodies of daughters. Twenty-nine-year-old Juana, a Latina mother of one living in California, told me how women in her family—her mother, in particular—had told her about their maternal embodiment experiences, but that her own experiences (with breastfeeding, for example) were very different from those. She explained, "My mom wasn't able to breastfeed us for a long time because she wasn't able to produce enough milk, and I thought maybe that was going to happen to me. So just a lot of either family or family friends were telling me that." Fortunately, Juana did not experience the same difficulties as her mother, but as a result, she no longer trusted her family to give her reliable advice about her health and body. Likewise, Greta had found her family relatively unsupportive of her efforts at breastfeeding. In response to her worries about her ongoing breastfeeding issues, Greta's mother told her, "If you can't do it, just stop. You were a formula baby. What's the big deal?" Although Greta's mother might have been trying to help, Greta viewed this attitude as a distinctly unhelpful sort of comment, which belittled her childrearing values and devalued the difficult work of breastfeeding that she'd been trying to accomplish.

There were some exceptions to this pattern, of course. Greta missed having her mother and sisters nearby to share tips with, and still other women told me that they used their mothers' experiences to help them anticipate what their own labor and delivery would be like. Suzanne was one such mother, but she also resisted this closeness, telling me, "[A woman's] labor is probably going to be more similar to a sister than to a mom, for some reason. But I didn't have a sister, and my mom was piping in my ear [about the baby coming early], every second...She thinks I am her, which causes anger for me. And I kept saying, 'This isn't healthy for me. Stop. The baby is going to come when it comes.'" From Suzanne's comment about being angry at her mother, who "thinks I am her," it becomes clear that middle-class women's widespread ambivalence about (and, in some cases, outright rejection of) their mothers' personal wisdom is not only about their being unreliable advice-givers. Critically, it seems that these women sought out the advice of friends they *chose*, rather than the mothers to whom they were born, because it

allowed them to maintain a unique self-identity, independent of their mothers' authority and bodies. Nadia, a 36-year-old White mother in California, demonstrated this ambivalence most clearly. Living in a new city with few friends nearby, she frequently called her mother for advice and support. Even so, she had gradually reconciled herself to the fact that "[My mother] does things her own way, and I do things my own way...It's been a process of me realizing that my lifestyle's different than the one I grew up with...It's been interesting, realizing that I'm different than my parents. And of course, my child will realize in certain ways that he's going to be different than me."

Middle-class mothers' eschewal of their own mothers' advice and support were tied to self-identity projects, but that rejection was made possible, in part, by the particular conditions of their lives. By the time they became mothers (averaging age 31 at the time of first childbirth), most of the middle-class women I spoke to had established independent careers and households (all lived with a male partner and their children). Geographic mobility was also a factor, such that these women frequently lived hundreds or thousands of miles from family members. Even while middle-class mothers spoke of rejecting their mothers' ways of doing things, this decision was facilitated by distance, maturity, and household autonomy. In contrast, low-income women in my study tended to be fairly young, averaging about 25 at the time of our interview, and 20 when they had their first child. Although some had friends who were also first-time mothers, they were more likely to turn to their own mothers, older sisters, and other female relatives for advice and support (a point that was not lost on WIC, which tried to shift these women's trust to the government program instead). Furthermore, a great many lower-income mothers actually lived with their mothers or other family members, relying on these relatives not only for emotional support, but also for help with financial and childcare.

Husbands, but not Partners

While grandmothers often gave advice that mothers found unhelpful or unwanted, middle-class women's husbands rarely even offered advice. And, while a concern women faced in accepting grandmothers' help was that of unwanted over-identification with their own mothers, gender divisions in heterosexual couples meant that identity-role boundaries between spouses appeared immutably fixed. In some cases, those divisions between husbands and wives were ascribed to physiological sex differences, most often in husbands' inability to bear children or to breastfeed. As Fiona described her reliance on a community of mothers, she explained,

It was good to have other people verify, or people who've been through what you've been through. Being a mom is a common thing, right? People do it every day, all around the world. So it's a new experience for you, but there's a gazillion people you can ask about it. So it's always nice to be able to have somebody to talk to who's been through the same thing. My husband has no idea. He wouldn't notice. And even if he did, if you told him, he'd be like, "Oh, okay." You know? (*laughs*) Because that's not something he will ever experience.

Fiona's assessment of how her husband would react to being told something about motherhood was that he could know the facts, but that these were not sufficient for him to fully understand and empathize with her. Similarly, Amy voiced her strong appreciation for "All the work and all the support I get from my husband... I can't imagine not having that," but then she continued, saying, "Having girlfriends that *really* know what you're going through, going through the same

thing, that you can talk to and share things with—I think that really helps.” Both Amy and Fiona’s statements suggested that they felt no amount of involvement or commitment from fathers could overcome their basic lack of the bodily experiences of pregnancy and childbirth, at least when it came to understanding mothers’ physical concerns. Not all mothers shared that attitude, however. Twenty-six-year-old Sadie, a White mother from Florida, told me how she did turn to her husband for health advice, but even she pointed out the unusualness of this situation: “I’d go to my husband [for advice], which is kind of different, I guess.” I asked why, and she laughed, responding, “People don’t usually go to their husbands for that sort of thing. But he knows a lot about nutrition. He’s a nurse.” Although Sadie’s particular situation—being married to a health professional—meant that her husband was particularly knowledgeable, her comments also acknowledge an embedded norm: women are responsible for maintaining their own health and bodies and their children’s, and when they require assistance, they should turn to other women—or, if necessary, health professionals—to provide it.

Even if most husbands could not empathize with the particular physical experiences that women underwent as part of maternal embodiment, they might, nevertheless, be involved as full co-parents by providing mothers with emotional (as well as financial) support, and they might also become engaged with the parenting decisions to be made. However, it was still largely the case that mothers were the primary knowledge-seekers and decision-makers when children’s health and development (as well as mothers’ own health) was at stake. In these situations, then, gender differences in parenting responsibilities were primarily social and institutional, not biological, though parents might still *understand* them as biological. For example, Stephanie sometimes left her husband to care for the children when she attended her weekly Sunday morning yoga class. She had worked hard to introduce new foods to her toddlers, and she made her own baby food, cooking, pureeing, then freezing batches of fruits and vegetables. She described the division of labor between herself and her husband thus: “I did all of the prep of making the food, ice cube tray[ing] it, sticking it in the freezer. I would say to my husband, ‘OK, feed Jackie lunch, feed Danny lunch.’ And my husband would be like, ‘What haven’t they eaten [yet this week]?’” Thus, even though Stephanie’s husband was aware of the rotating food schedule she had devised—and worked to maintain it when he was in charge of meals—it is obvious that he viewed her as the final authority, while he acted as her deputy when she was away. Juana’s husband also seemed to view himself as a helper. Juana told me, “My husband does help, but I think because I am the primary caregiver, he hasn’t had to be too firm with [our son]. He will say things like, ‘Remember Mommy said not to do that.’” By citing Juana’s authority, her husband reinforced—both for himself and for their son—that Juana, not her husband, was the primary parent.

Lara, a 40-year-old White mother living in California, also described a situation in which her husband coparented by supporting her decisions, saying,

Usually we’re on the same page... I didn’t really think about it until we visited my cousin and her husband who have twins, who just turned two. They said, ‘It’s pretty cool because Joe follows what you do.’ They have a lot of disagreements about parenting. And for the most part Joe has always just followed what I do in large part because I’m the one that reads everything and probably cares more about it. I’m home more with them than he is.

Charlotte’s situation was similar; speaking about one particular issue (weaning), she told me, “I’ll usually have gotten a pretty good sense of what that’s going to be like, based on books I’ve

read, talking to friends, sometimes talking to [my daughter's] teachers—she goes to day care. And then I'll compile that information and talk to my husband about it." I asked whether he generally supported her approach, and she replied, "Yeah, because he hasn't done the research. He has no idea." Importantly, while many middle-class women like Charlotte and Lara incorporated the identity of "researcher" into their self-concepts—narrating stories about expertise and education even as they applied their skills to mothering—these stories also reveal that mothers disproportionately continue to bear the burden of managing children's bodies, health, and day-to-day life (a trend described in previous decades by authors such as Marjorie DeVault [1991] and Arlie Hochschild [(1987) 2003]).

In some cases, mothers told stories that indicated they were satisfied with this arrangement (or, at least, that they could put a positive spin on it). But in other cases, my respondents would have liked considerably more support from their husbands. Greta told a story that was fairly common: "My husband has a pretty demanding job, so I find that I'm the one that's doing almost all the parenting, which is hard." In many cases, husbands stepped up their work commitments when their wives became pregnant, in anticipation of the financial demands of a baby. Yet in so doing, they often left their wives to deal with the day-to-day work of caring for a baby and developing childrearing expertise. Amy also described feeling like a single parent in the days following her son's birth.

[My husband] didn't take a paternity leave, so I did everything on my own, basically, right from the start. My son was born on September 3, and guess what? Class started that week, so there was no way that he could not teach class. I thought he could pass it on to a TA, but it didn't happen. So I was basically on my own when it came to that.

And for Nadia, who relied on phone calls to her mother for support because she lived far away from her good friends, her husband did little to alleviate her feelings of isolation. Nadia had not planned to become pregnant, and she struggled with negative feelings about being a mother. More specifically, she did not feel ready to be a primary parent, but her husband's work schedule pushed her into that role. She explained, "I worried that my husband would be at work a lot. I just was worried that I wouldn't have enough support. And basically it's true. I really don't."

Thus, while female peers with similar values and children close in age formed women's ideal reference groups as they attempted to navigate the challenges of new motherhood while maintaining a consistent sense of self, there were two other potential sources of support that middle-class mothers often would not or could not draw upon: grandmothers and fathers. In the case of grandmothers, women often asserted that their own mothers *didn't* know best, whether due to differences in mothers' and daughters' healthcare philosophies or because they yearned to establish a sense of self distinct from their mothers' bodies and identities. In the case of their husbands, women faced different challenges. With women having personally chosen their husbands and, ideally, sharing similar values and hopes for the future, it might stand to reason that fathers would be nicely suited partners and advice-givers for the middle-class mothers in my study. Nevertheless, this situation rarely occurred—sometimes because women expressed a need to talk to other women who had gone through similar physical experiences (which husbands could not share), but more often because of ongoing gender divisions in work and childcare responsibilities that had little to do with physiological differences between the sexes.

Negative Comparison Groups: Dissimilar Mothers as Others

Up until this point, this chapter has focused on the positive reference groups that mothers established as a way of shoring up their identities and seeking validation for the identity-enhancing healthcare and childrearing quests they pursued. In many middle-class mothers' stories, however, there lurked a shadow comparison group: rarely named or explicitly acknowledged, particular types of mothers who formed a negative comparison group against whom middle-class mothers could measure themselves. Both types of comparison group—positive and negative—provided mothers with validation for their identities and parenting choices, but one operated through affirmation, while the other served as a site of disavowal and disidentification. It is this second, more elusive reference group that reveals middle-class mothers' concerns about status and identity most clearly, and to which I will now turn.

Earlier in this chapter, I described Fiona's comparison between her own eating habits and those of her husband, wherein she explained, "I'm just not somebody that's into extremes." Fiona's point, here, was to position herself as a type of person who valued balance and moderation in every sphere of life—a common technique by which mothers in my study ascribed moral worth to their choices, whatever those choices might be. Less common, however, was Fiona's explicit reference to a known other (in this case, her husband) while making that comparison. Stephanie, for example, explained her choice to manage her diet while pregnant thus: "I didn't want to be one of *those people* who started eating a pint of ice cream every day, because I had been much larger and I knew it would be really easy to gain like 60 pounds while I was pregnant and never lose it" (emphasis added). Similarly, Misty told me, "I didn't use my pregnancy as an opportunity to eat whatever I wanted, eating for two. I didn't keep that mentality. I tried to put on a healthy amount of weight, eat right, and do the right things." Both Stephanie and Misty framed their prenatal weight management as sensible by implicitly referring to unnamed Others ("those people"), mothers who were, in Fiona's words, "into extremes." Stephanie further positioned herself as taking the sensible, balanced approach by describing a distant acquaintance at the other "extreme":

[She's] having a baby in a few weeks, and she just advertised [on Facebook] yesterday that she went for a mile-long swim, and she went to her doctor afterwards and she'd only gained 18 pounds. And she's 35 weeks!

To Stephanie, this other mother's habits indicated that she was "image-obsessed" and not prioritizing her own or her baby's health; by the same token, she told me that gaining 60 pounds during pregnancy would swing unhealthily far to the other extreme. Thus, for Stephanie and many of the other women in my study, the Platonic notion of moderation as a virtue served to govern their approaches to mothering and self-care. Perhaps not surprisingly, though, one woman's moderation was another woman's extreme. Stephanie had developed a comprehensive schedule for introducing new foods to her children, which she typed up as a spreadsheet and shared, on request, with her friends. To Lee, though, such behavior was "crazy":

[During pregnancy] I was very conscientious about calcium and things for [my daughter's] brain development, probably overly conscientious. I didn't really track it or anything. I'm sure there are people who have spreadsheets, [but] I did not have spreadsheets or anything crazy like that.

In some cases, mothers overcame what seemed like a great deal of cognitive dissonance in order to identify their health habits as moderate and balanced. Greta, for example, told me about her insistence on limiting her children's sugar intake. She took away their Halloween candy and, in response to a bank teller who asked whether her daughter would like a lollipop, she stated indignantly, "Why would you ask me that? No you can't!" Yet, describing her recent interaction with another mother, Greta went to great pains to paint herself as "not obsessive":

You start off by giving kids Cheerios for a little snack, and one woman was like "Oh, Trader Os are better." I'm like, "What's wrong with Cheerios?" "Too much sugar." I'm like, "Are you kidding me? It's Cheerios!" And that's the level of obsessiveness...that people are at today. And I'm like, "That's insane!"

Mothers' comparisons to similarly-situated peers with different values thus often hinged on judgments about which health and parenting behaviors were balanced, moderate, and sensible, and which were "crazy," "insane," or "extreme." In accordance with late modern self-identity formation's dependence on self-reflection, these women had considered their own approaches carefully and developed a narrative for why they made those particular choices (as well as what differing choices said about other parents). Perhaps because of their relative social closeness, middle-class mothers took special pains to distinguish their own values and choices from those of other middle-class women with whom they did not agree. This practice enabled them to assert not only particular types of values, but also claims to being a particular type of self: an enduring sense of identity tied to, but not solely dependent on, their status as mothers and their membership in a privileged class.

To be clear, none of the middle-class mothers I interviewed spoke very disparagingly about another mother's choices (with the exception, perhaps, of their own mothers). Far from the competitiveness of the so-called "Mommy Wars," I suggest that most middle-class mothers discursively Othered their peers for one of two reasons. First, the imperative to make ongoing, dedicated body-work a central part of their self-identity as women and mothers required my subjects to define clearly what their own health values would be; the construction of symbolic boundaries (Lamont 1992) to distinguish between their own chosen path and other possible routes to health was helpful in that regard. Second, few of these women viewed themselves as crusaders for health; instead, their comments tended toward the defensive. As such, their comments may be read as a half-conscious acknowledgment of the disciplining pressures exerted by other women's health quests. If peers from a mother's reference group begin to incorporate increasingly demanding practices into their health and body projects, she has two options: to follow along, or to narratively frame her eschewal of those practices as a reasoned choice in line with her personal long-term goals (thereby reaffirming the normative value of the quest even as she rejects particular practices as being peripheral to that quest).

In contrast, middle-class mothers' references to women from lower economic and educational backgrounds tended to be fairly vague—usually embedded in references to other "types" of mothers—but they did happen in the course of our interviews. Nadia was one of the few women who made this connection explicit. She told me, "I won't buy the 'Go-Gurt' [an artificially flavored and colored yogurt marketed to children]. I don't do that kind of thing." I asked her to elaborate on her unwillingness to serve her son certain foods, and she responded,

I was online...watching some show. And they have the macaroni and cheese in a bag now. So you just open the bag, dump it in a [pan], and bake it in the oven. I was just like, yuck! [making a face] I have my limits. You know, the food is now the thing that separates [classes]...it's a marker of class more than cars, more than clothes, more than anything else.

For Nadia, even an awareness that access to, and knowledge about, healthy food was tied to class privilege did not prevent her from asserting (by making a disgusted face and stating, "I have my limits") that her food choices were morally righteous.

In other cases, mothers constructed negative reference groups on the basis of knowledge and educational disparities. Most middle-class women I interviewed believed that taking proper care of oneself and one's children required extensive knowledge and understanding. Christine, a White, 37-year-old Florida mother who received WIC aid but was culturally middle-class, said of her special diet to control her gestational diabetes, "You have to have a degree in rocket science to figure it out." While Christine did not have a degree in rocket science, her hyperbole was not too far off the mark: she was currently finishing her second Master's degree at the time of our interview. Her toddler was eventually diagnosed with diabetes, and managing his insulin and diet fell to Christine, who said, "It just seemed like a mathematical nightmare to me. It seemed like a very intimidating thing." The implication of Christine's statements was that women without her educational advantages would be utterly unable to follow a doctor's orders. Stephanie added that she'd found the information for pregnant and nursing mothers to be often misreported or contradictory; "You know," she said, "that creates a lot of confusion among very educated mothers. Imagine what kind of confusion it's creating for mothers who maybe don't have enough education to be able to analyze what's there and make a decision." And, as one of the only middle-class mothers in my interviews to construct a close friend or relative as a dissimilar Other, Joan expressed both sympathy and exasperation when describing her sister's ongoing bad eating habits, purportedly due to her financial and time constraints as a low-income single mother:

[My sister] says she doesn't have time to read labels on packages at the supermarket, to see what's in them. And I think, you only have to do it one time, and then you can remember the next time, if you go to pick this up, "Oh yeah, that has high fructose corn syrup," or "Oh yeah, that has hydrogenated oils in it." I personally don't see what's so hard about reading a label one time, and making a different decision.

To Joan, who worked to teach her own young children about the dangers of high fructose corn syrup and hydrogenated oils, it was unconscionable that her sister was not more aware of what she was eating. Yet, she and her sister grew up in the same upper-middle-class household with a stay-at-home mother who *did* teach them about how to eat right; to Joan, then, her sister's bad habits seemed to be due to a lack of effort, not a lack of knowledge—making a "different decision" simply required taking a few seconds to read a label. Joan's distinction between her own food and childrearing practices and those of her lower-income sister resonates with the statements several other women made to me. To these mothers' minds, the things they valued as being crucial to good nutrition and good mothering were within reach because of their various economic and educational advantages. Most women, like Christine and Nadia, expressed

sympathy (rather than Joan's more judgmental tone) for women who, for example, lacked the education to understand a complex diet or the money to buy organic produce; yet, by maintaining that such practices were ideal for self- and child-care, they were asserting—however softly—that their mothering practices were superior to those of lower-class women. Thus, regardless of the material consequences of these practices (that is, whether they actually produce better outcomes later in life), the middle-class mothers I spoke to clearly thought of their practices in terms of class advantage and status transmission. Finally, Joan's indictment of her working-class sister's eating and purchasing habits hints at the moral valuation—and the classing—of choice itself, to which I will turn in the next chapter.

Mothers on the Margins

As a final point, many of the women I interviewed spoke defensively about their own parenting choices, an attitude they often expressed while drawing symbolic boundaries between themselves and Others. Virtually none attempted to reach across those boundaries. This pattern became clear when women talked about other women as sources of support. Informal “mommy groups” formed an important site of both support and norm transmission for new mothers, and it was often within these groups that women became comfortable with defining their own health and body philosophies. Yet, as several women's comments suggest, not all women were equally at home in such groups. Louise, for example, felt somehow out of step with the women in her group when she went to a live event—a sense she indirectly attributed to her lower-class background. Cass—who also came from a more modest family background—tended to defer to her new friend Emily when I interviewed them together; while Emily spoke confidently about her history of living abroad and the relative merits of American and European childrearing practices, Cass tended to ask Emily questions about those things. For upwardly mobile women like Louise and Cass, then, accessing the support of a middle-class mothers' group posed additional challenges. Given the importance so many group members placed on making the group a safe haven full of women with similar values, attitudes, and knowledge, women who were dissimilar in some way may have kept silent more often or worked harder to blend in. Failing that, they sometimes abandoned their groups.

Indeed, while it would seem that any group of new mothers could find a range of common ground on the basis of their shared experiences, many women in my study explained that, as Bree said, they chose friends and support groups who “value[d] identity outside of being a mom.” Groups formed on this basis—unlike, for example, hospital-organized groups based on similar ranges of delivery dates—are less likely to include very much racial/ethnic and class diversity. As Michèle Lamont explains, “making distinctions on the basis of tastes and lifestyles is equivalent to making distinctions on the basis of class background” (1992: 103). Where, then, do women on the margins turn?

As noted above, some of these women (such as the upwardly mobile Cass) do their best to fit in and learn the norms and values of the group they join, gradually acquiring the cultural repertoires of their would-be peers. Still others, like Louise, tried to join but were frustrated and gave up, reasoning that the Otherness they felt overshadowed any benefit they might gain from being part of the group. And Nadia, who came from a middle-class background but who, having moved across the country shortly after the birth of her son, felt culturally distant from other mothers who lived in her area, showed one possible response to the cultural closure of local mothers' groups: she had very little to do with her neighbors, and instead relied on frequent phone calls to her mother for support.

Finally, while there were very few women of color among my middle-class respondents, work by Dawn Dow (2011) suggests that racial/ethnic homogeneity in middle-class mommy groups continues to be a challenge. Middle-class Black women who wish to join such a group may find themselves the only person of color in that group; shared class background may not be enough to make them feel utterly at ease with their peers. One benefit of participating in such groups is having a space in which to vent about childrearing frustrations and concerns, but, as Dow shows, these women may worry about their negative emotions being taken out of context, and thus, they avoid “airing dirty laundry” in such settings. For such women, one solution is to join (or, often, to form) groups specifically aimed at middle-class women of color. Similar to upwardly mobile White women, though, it seems likely that a number will simply drop out, eschewing both the normalization and the possibilities for support that group membership brings.

Conclusion

For middle-class mothers in my study, maternal embodiment brought with it an expansive set of choices (made possible by their economic privilege within a neoliberal market economy) but, also, a broadened sense of risk. Accordingly, their decisions about how best to care for themselves and their children throughout pregnancy, childbirth, and the postpartum period reflect both the imperative that they must make the “right” choices for health (which manifests as *questing discipline*) and the opportunity, within late modernity, to construct coherent trajectories for themselves that align consumption choices with personal ethics and self-identity. Although child health and development—as well as mothers’ own health—were primary considerations when women sought out particular tips and techniques for managing their pregnant and postpartum bodies, few middle-class women in my study agreed that there was one best way to achieve optimal health outcomes. Instead, these women pursued dietary practices, exercise routines, and childrearing strategies that aligned with preexisting value systems and self-identities that they claimed.

And yet, while Giddens’ theory tells us about individual self-making, self-narrativizing projects, it has little to say about the role of community: in particular, positive and negative reference groups. For middle-class mothers in my study, selecting reference groups and sources of support during the maternal embodiment was a process fraught with concerns about maintaining mothers’ coherent sense of self and moral center. Few women made such decisions about self- and child-care wholly on their own, although independent Internet research formed an important component of most mothers’ gradual development of health and body expertise. Often eschewing grandmothers’ advice and lacking husbands’ full involvement, middle-class women turned to their like-minded, similarly situated peers as primary sources of information and support. These friends, frequently discovered through “mommy groups” that women joined, provided validation for mothers’ choices and identities. In day-to-day interactions, they also reinforced each other’s commitment to the questing discipline they shared.

Not coincidentally, mommy groups were unlikely to include much socioeconomic or racial/ethnic diversity. Yet, despite these other women’s exclusion from middle-class women’s childrearing communities, they were never fully out of mind. A final component of middle-class mothers’ construction of maternal selves was their often-subtle, yet crucial, delineation of negative reference groups: maternal Others. In some cases, mothers defined themselves in opposition to women of similar social backgrounds who nonetheless espoused different health practices or values, and thus represented negative “types” of person. In other cases, though, the shadowy Others against which middle-class mothers measured their body value systems and

practices were lower-income, less-educated women, such as the WIC-enrolled women I describe in the previous chapter. It is in this last group that the multiple purposes of middle-class women's identity-based choices and reference groups become clear. On one hand, these women explicitly told me that their like-minded peer groups helped shield them from the negative judgments of others, who might endorse different values for how best to care for oneself and one's child during the maternal embodiment period. On the other hand, the negative reference groups that mothers established suggest that they, too, viewed some self- and child-care practices as *better* than others, not merely *different*.

Furthermore, the differences between mothers' negative characterizations of same-class peers and those they made of lower-income Others are significant. For a middle-class mother to be described as "crazy," "extreme," or "insane" in her pursuit of her own and her child's welfare is more of a backhanded compliment than a true condemnation. Such mothers might be overly controlling—or, as some women I spoke to put it, "Type A"—but their motivations are deemed to be basically good: their flaw is that they care too much. As such, these mothers are perceived to still abide by the dictates of questing discipline. By contrast, low-income mothers are portrayed as not doing enough, whether due to lack of resources, lack of knowledge, or, as at least one woman (Joan) suggested, lack of effort. These classed meanings of the work and effort that women carry over into societal understandings of mothers' agency, to which I will turn in my next chapter.

CHAPTER FOUR

Bearing Babies, Bearing Class: Class-Conditioned Agency and the Maternal Body

In the previous two chapters, I have shown how lower- and middle-class women approach the bodily challenges of motherhood within markedly different social contexts. For poor and working-class mothers, centralized state-run agencies like WIC seek to transform these women into compliant, self-regulating citizen-subjects who are empowered, not to make claims on the state, but to pursue health for themselves and their children as independent actors. This agenda springs from neoliberal ideology, which has downsized most of the welfare state and, in the welfare programs like WIC that remain, has honed their techniques for subjectifying the poor. Women in WIC are not mere pawns of the state—neoliberal subjectification demands that they be formally free to choose different paths for themselves—but, with few exceptions, these women adopt WIC’s health and body norms as their own.

Middle-class mothers in the U.S. live under the same neoliberal state, but their socioeconomic position frees them from constant contact with—and surveillance by—that state. Instead, these women experience neoliberalism as a world brimming with both choice and risk. Using the social, cultural, and material resources at their disposal, middle-class mothers navigate a vast landscape of possibilities for self- and child-care, not only avoiding danger, but also seeking out practices and ideologies that will align with their preexisting sense of self-identity.

Thus, the structural conditions facing women across classes differ drastically. The contrast between the relatively inflexible guidelines at WIC (softened slightly by the program’s *gentle discipline*), which represent only a tiny fraction of the limiting constraints on low-income women’s actions, and the questing, self-affirming journeys of middle-class mothers might, at first glance, appear to represent the opposing forces of structure and agency: namely, low-income women’s bodily fates reflect the overwhelming power of social structure, while middle-class women’s bodies are subject to their own agentic desires. Yet, by naming the normative pressures middle-class women face *questing discipline*, I have sought to problematize such a reading. In this chapter, I will compare mothers’ self-care strategies across classes in order to elaborate and extend that critique.

Specifically, I examine how differing social contexts structure all women’s possibilities for agency and action as they care for their bodies during and after pregnancy. For many decades, discourses on motherhood in the United States have revolved around questions of embodied choice and control. Among feminist activists for health and reproductive justice, choice and control appear as rights—basic tenets guaranteeing all women’s bodily integrity and freedom from external control. Meanwhile, popular and government-sponsored maternal advice manuals (such as those from WIC) frame choice and control as questions of responsibility—to the extent that women’s bodily choices affect their children’s health, they are judged as good or bad mothers; to the extent that women exercise self-control with regard to their own bodies and health, they are judged as competent, adult citizen-subjects.

These two frames exist simultaneously and in tension with one another. Yet, with their emphasis on control and freedom of choice, both refer back to Western cultural discourses of human agency. In this chapter, I examine women’s actions during the maternal embodiment period in order to theorize agency intersectionally, as a product of the gendered, classed, and, above all, embodied conditions within which subjects reside. Feminist philosopher Iris Marion Young (1990) argues that the maternal embodiment period may be particularly fruitful for this

purpose. During this time, the porous boundaries between mothers' and children's bodies issue a radical challenge to classical liberal notions of the discrete, independent subject. In making this argument, Young draws on a central tenet of body and embodiment scholarship: the lived experience of the body is inseparable from one's understanding of the world and sense of self.

Young's suggestion is provocative, but she bases it on her own experiences and those of other relatively class-privileged women who have freely chosen pregnancy and for whom "pregnancy can be experienced for its own sake, noticed, and avowed"—she adds that "[m]ost women in human history have not chosen their pregnancies in this sense" (p. 161). Yet why should it be that middle- and upper-class women's bodily experiences carry the greatest potential for retheorizing agency and identity, and what might we gain by looking for agency in the embodied experiences of low-income mothers, who tend more often to be framed as lacking agency?

Taking a comparative approach, I will focus on three major health and body norms mothers encounter: (1) eating healthily while pregnant; (2) exclusive breastfeeding; and (3) losing weight postpartum, to return to the conventional norm for feminine attractiveness. Although these norms were widely shared, women's responses to them differed. These classed patterns in women's care and management of their bodies during maternal embodiment allow me to theorize multiple, class-conditioned *agencies*.

With regard to the body—and, especially, maternal embodiment—agency is traditionally defined as the ability to make informed choices about and to exercise autonomous control over the body and its care, even as pregnancy and childbirth present considerable challenges to realizing these ideals. Middle-class mothers certainly spoke of their self-care practices to me in this way, thus making their actions legible as evidence of agency, forethought, and careful planning (as well as coherent self-identity). In contrast, poor and working-class mothers have long tended to be framed as lacking bodily agency. Indeed, I did not observe the middle-class discourses of agency and self-control among these women. However, I will argue that these women had not an absence of agency, but an alternative form of agency.

In contrast to middle-class mothers' *rigid agency*, which was marked by an unyielding dedication to fixed goals and ideologies for the body, poor and working-class mothers in my study instead tended to exercise *flexible agency*, adapting to circumstances out of their control and doing the best for their bodies with the available options. This notion of multiple agencies, which I develop following from Saba Mahmood's (2005) exhortation to rethink agency as "a modality of action," contradicts both mainstream discourses about poor women's (and, often, women of color's) lack of self-controlled agency, as well as feminist scholars' tendency to seek marginalized women's agency in acts of resistance. Furthermore, understanding class differences in agency in this way helps to expose how common wisdom about mothering "best practices" is based on an assumption of middle-class subjectivity. Ultimately, contra Young, I argue that it is poor and working-class women, not middle-class women, who are most able to adopt the alternative modes of agency called for in maternal embodiment.

Agency, Embodiment, and Inequality

Why Agency?

The modern notion of agency has its roots in liberal political philosophy and, as such, it resonates strongly with the contents of neoliberal subjectivity described in previous chapters. As formulated in the works of early philosophers like Hobbes, Hume, Kant, and Locke, human agency is defined as the capacity to engage in free, rational, and self-interested action. Those

characteristics also describe the ideal subject of a (neo)liberal political regime. Paul Benson (1990) notes that this description of agency prizes the autonomous self, explaining,

The primary condition of free agency is the agent's having the power to control, regulate, or rule over her conduct...The free agent's control standardly is described as an executive power, the power decisively to initiate courses of action in the face of available alternatives, the ability to do or not do. (p. 49)

Benson adds that free action entails the ability not only to exert one's will on the world around oneself, but also to turn that will toward one's own self "to master ignorant desires, powerful appetites, physical urges...Being free has meant being capable of self-domination. Those aspects of oneself which are 'really' one's own must be able to control those aspects of oneself and the world which are not" (p. 50). Although Benson's chosen terms—"desires" and "appetites," for example—may be used to refer to intellectual or cultural preferences, it is also the case that the liberal conception of agency fundamentally pits the human mind against its most animalistic bodily needs and urges. Correspondingly, the free, deliberate choices one makes regarding the use and cultivation of the body stand in as evidence of one's agency and, thus, as markers of full human subjecthood and worthiness.

Agency and Stratification: Gender and Class

Several authors have critiqued the ways in which discourses of agency that highlight bodily self-control and self-determination are both gendered and classed. The feminist literature on embodiment suggests that women, in particular, confront normative expectations for bodily discipline and self-control. Young theorizes what she calls "feminine bodily existence," which is characterized by "the woman's experience of her body as a *thing* at the same time that she experiences it as a capacity" (1990: 147). In other words, women are taught, from a young age, to view their bodies as objects to be acted upon and, in particular, to be controlled, which splits their focus and inhibits their capacity to use their bodies in pursuit of their goals. Rather than a means to an end, the body itself becomes the target of women's efforts.

Furthermore, even as classical liberal understandings of agency endorse bodily self-control for all subjects, women have long been portrayed as having particular difficulty with this task—as being stubbornly embodied. Susan Bordo ([1993] 2003: 143) explains that in Western traditions, "[W]omen, besides *having* bodies, are also *associated* with the body." Such discursive linkages between women and bodies have been extensively examined in classic second-wave feminist theory (e.g., Beauvoir 1949; Ortner 1972) and are often attributed to societal anxieties about women's bodies. Both scientific (Fausto-Sterling 1992) and artistic (Fischer 1992) discourses portray female reproductive functions as illness, insanity, and even demonic possession: in other words, as a loss of control. Furthermore, family arrangements in the West have, historically, asked women to shoulder the responsibility of caring for the bodily needs of others (Beauvoir 1949; DeVault 1991; Hochschild [1989] 2003). In short, these gender arrangements create a climate in which the body, for men, is comparatively unremarkable and unproblematic; for women, it requires constant vigilance, due to both the cultural imperative that women discipline their supposedly unruly bodies and the social expectation that women will nurture and sustain the bodies of others, most notably—but not exclusively—as mothers.

Yet standards for bodily control are not only gendered, but also classed. In describing aristocratic Victorian ideals of slenderness, Bordo writes, "a frail frame and lack of appetite

signified not only spiritual transcendence of the desires of the flesh but *social* transcendence of the laboring, striving ‘economic’ body” ([1993] 2003: 116). Though particular body types and behaviors may have practical uses, bodies are judged often not by what they can do, but by what they signify. Michel Foucault ([1976] 1990: 125) posits that self-control and body management may be status signifiers deployed by those in positions of greater privilege:

The emphasis on the body should undoubtedly be linked to the process of growth and establishment of bourgeois hegemony: not, however, because of the market value assumed by labor capacity, but because of what the “cultivation” of its own body could represent politically, economically, and historically for the present and the future of the bourgeoisie.

Here, Foucault’s notion of bourgeois body cultivation seems to agree with Pierre Bourdieu’s ([1977] 1984) concept of a “class body”—that is, the characteristic physical appearance and presentation of bodies belonging to a particular class location. Bourdieu writes,

The body, a social product which is the only tangible manifestation of the ‘person,’ is commonly perceived as the most natural expression of innermost nature...The legitimate use of the body is spontaneously perceived as an index of moral uprightness, so that its opposite, a ‘natural’ body, is seen as an index of laisser-aller (‘letting oneself go’), a culpable surrender to facility. (pp. 192-193)

Extending Bourdieu’s theory further, it stands to reason that individuals might stand to gain (in both status and resources) by using their bodies to demonstrate control, civilization, and “moral uprightness”—in other words, to demonstrate *agency*. To do so, one must both articulate a specific bodily ideal—a choice about the body—and then achieve it (which demonstrates control).

Challenging and Extending Notions of Agency

Traditional definitions of agency that cast it as a universalizing question of “free” will elide the ways in which this particular capacity for action is tied to specific sociohistorical conditions; the ideal “free” subject who will exercise such agency is thus revealed as someone with a relatively high degree of social and bodily privilege: likely male, White, middle-class, and in good health (among other things). And yet, rather than appearing as the effect of the privilege these characteristics bestow, agency is more often portrayed as the cause, a moral and tenacious exercise of willpower that legitimates one’s social position.

Just as feminist standpoint theorists repudiate the unmarked status of the author in sociological inquiry in favor of one whose particular standpoint is acknowledged (Haraway 1991; Hartsock 1987), a handful of feminist authors have likewise begun to reveal the implicit gendering of classical definitions of supposedly universal “free” agency (Mahmood 2005; Young 1990). Less common, however, is a parallel attention to class. I argue that feminist critiques of agency offer a potential tool for analyzing agency in terms of class insofar as they challenge us both to scrutinize longstanding definitions of agency that privilege certain subject positions and to look for other manifestations of agency outside of those subject positions. For the remainder of this section, I will discuss two feminist challenges to the notion of agency, and I ask how these

insights might help us to advance an intersectional understanding of agency, revisiting the concept from the perspective of both gender and class difference.

Young suggests that maternal embodiment poses a challenge to the autonomous, discrete self upon which liberal notions of agency are premised. She writes, “The pregnant subject...is decentered, split, or doubled in several ways. She experiences her body as herself and not herself” (1990: 160). This blurring of bodily boundaries—experiencing the body as both self and not-self (the fetus)—challenges our understandings of bodily agency. If, as Benson (1990: 50) writes, classical agency requires distinguishing between “aspects of oneself which are ‘really’ one’s own...[and] those aspects of oneself and the world which are not,” how might that understanding shift when, as in maternal embodiment, the boundaries between self and other are blurred—in Young’s words, when “the transparent unity of the self dissolves” (1990: 161)? Her aim in raising this critique is to destabilize the assumption of an unchanging, clearly bounded embodied self that undergirds both medical norms and theories of human agency. If maternal embodiment, with all that it entails, were to be recognized as a normal variant of human bodily experience, rather than an illness or an aberration, what might be the consequences for how we understand the self and its actions?

A second critique comes from Saba Mahmood (2005), who challenges classical notions of agency—as well as some feminist attempts to reclaim agency—on the grounds of their being culturally limited. Her research, which examines devout women’s participation in a conservative Islamic piety movement in Egypt, questions “the belief that all human beings have an innate desire for freedom, that we all somehow seek to assert our autonomy when allowed to do so, that human agency primarily consists of acts that challenge social norms and not those that uphold them” (p. 5). Instead, she offers an alternative definition of agency that emphasizes responsibility and the “ability to effect change in the world and in oneself” (2005: 14) without judging the ends toward which that change is directed.

Mahmood asserts that while it is important to seek out the spaces within which marginalized people act, it is a mistake to look for agency only in moments of resistance (as she describes many feminists doing). Instead, she advocates for a grounded theoretical conceptualization of agency, tied to the cultural and historical context within which marginalized subjects act:

If the ability to effect change in the world and in oneself is historically and culturally specific...then the meaning and sense of agency cannot be fixed in advance, but must emerge through an analysis of the particular concepts that enable specific modes of being, responsibility, and effectivity. (2005: 14-15)

Such an analysis of agency, she adds, will focus not on determinations of whether particular individuals are agentic, but on the modes of action open to them within certain cultural contexts and social locations (p. 32). Thus, Mahmood’s work redefines agency as a field of socially structured capacities for action: not agency versus structure, but agency always *within* structure, with no agents assumed to be “neutral” or free from social and historical influences.

In this chapter I take on and extend Mahmood’s analytical strategy, working to build an intersectional understanding of agency from the ground up. In so doing, I aim not to judge individual subjects as agents or not-agents, but to use these women’s words to understand the choices they make and the ways in which structural conditions—class inequalities in particular—shape the modes of agency available to them. Furthermore, I take seriously Young’s (1990) point

that agency is fundamentally tied to notions of the embodied self. Thus, I look to the bodily experiences, both shared and divergent, of women across classes during the period of maternal embodiment.

“Good” Mothers, “Bad” Mothers, and the Element of Choice

You’ve got nine months’ worth of meals and snacks...ahead of you—each one of them an opportunity to feed your baby well before he or she is even born. So open wide, but think first...Remember that each bite during the day is an opportunity to feed that growing baby of yours healthy nutrients. (Murkoff and Mazel [1984] 2005: 90)

As this quotation from *What to Expect when You’re Expecting*, the so-called “Pregnancy Bible,” demonstrates, contemporary motherhood in the U.S. is popularly understood to require deliberately cultivating one’s own body and that of the growing child, both *in utero* and postpartum. Even prior to conception, *What to Expect* dedicates a chapter to pre-pregnancy self-care, to help would-be mothers “get into tip-top baby-making shape” ([1984] 2005: 2). In its injunction that mothers should “think first,” *What to Expect* presents maternal embodiment as a state subject to planning and control—a site in which mothers can and should exercise agency.

The ideal of self-controlled agency carries over into the various maternal embodiment norms that women face, even as such norms—including pregnancy eating habits, breastfeeding, and postpartum weight loss—tend to be framed as neutral, health-maximizing practices. Social norms for maternal embodiment begin in pregnancy and continue into the postpartum period, wherein “good” mothering is judged according to the choices that women make for their own bodies and their children’s.

A vast body of literature, both popular and scholarly, is devoted to understanding social judgments of “good” and “bad” maternal embodiment. In the early 2010s, *Time* ran a number of cover stories on health and childrearing topics, including one on the “fetal origins” of human health and behavior (“How the First Nine Months Shape the Rest of Your Life,” September 22, 2010), which targeted mothers’ prenatal activity as a determinant of their children’s life chances, and another on breastfeeding and attachment parenting, which showcased a svelte White mother breastfeeding her 3-year-old son and carried the provocative title, “Are You Mom Enough?” (May 21, 2012). Stories like these join more than two decades’ worth of coverage of the so-called “Mommy Wars” in periodicals like *Newsweek* and *The New York Times* highlighting debates over the childhood benefits of having a working mother versus a stay-at-home mother. The confrontational language of many of these articles focuses on the content of women’s choices, implicitly or explicitly pitting mothers against one another.

The irony of these debates, many scholars have noted, is that they create unattainable and contradictory standards for “good” motherhood (Hays 1998; Wolf 2011). A mother may, of course, be labeled “bad” in her bodily habits if she takes illegal drugs during pregnancy (Roberts 1999) or abuses alcohol (Swift 1995). Not all condemnations of “bad” mothers involve such blatant norm violation, however. Women are expected to acquaint themselves with medical knowledge and to follow scientific guidelines for cultivating their own bodies and those of their children (Apple 1987, 1995), but also to learn how best to raise concerns with their doctors so as to avoid being labeled noncompliant “bad patients” (Bessett 2010). Although pregnant women are released, to some extent, from requirements for maintaining a slender and sexually

objectifiable body (Young 1990), they are now “eating for two” and are expected to select the best quality, most nutritious foods for that project (Copelton 2007; Lupton 1996; Markens et al. 1997). Toward the end of pregnancy, women face conflicting messages about whether to opt for medically managed labor or to attempt “natural” childbirth (Brubaker and Dillaway 2009; Lazarus 1994; Nelson 1982). Judgments about maternal embodiment choices do not end at childbirth. Thereafter, “good” embodied motherhood entails breastfeeding (Blum 1999; Shaw 2004; Stearns 1999; Wolf 2011), but only if the maternal body is sufficiently pure: so-called “viral mothers” who have communicable diseases become “bad” mothers when they breastfeed (Hausman 2006). Likewise, children should be breastfed on demand but not in public spaces (Hausman 2007), and, while many official sources like the World Health Organization and La Leche League advocate breastfeeding into early toddlerhood, or older, doing so opens mothers up to charges of child sexual abuse (Umansky 1998). “Good” mothers make sure their children are well nourished, of course, but they are also expected to prevent their children from becoming overweight; in extreme cases, mothers of very large children have been charged with criminal child abuse and neglect (Solovay 2000), which Boero (2009) describes as part of a larger trend of “mother blame” connected to the so-called “obesity epidemic.”

One point these “cultural contradictions” (Hays 1998) of motherhood make clear is that, while discourses about “good” maternal embodiment often reference mother and child health, they are not about health alone. Many scholars (Bessett 2010; Blum 1999; Boero 2009; Lazarus 1994; Roberts 1999; Tice 1998) find that norms for “good” maternal embodiment are also classed and racialized, with non-White and lower-class women’s bodily practices more likely to be condemned as evidence of “bad” motherhood. Pointing to material and structural inequalities, these authors reveal how moral judgments about mothers’ self-care choices tend to uphold White, married, heterosexual, slender, middle-class women as ideal mothers.

As much of this past scholarship makes clear, the content of “good” motherhood practices is highly variable and contradictory, and the “right” choice for maternal and child health one year may be discouraged the next. Perhaps the constant, then, is societal valuation of a particular mode of agency with which mothers approach these decisions. In the sections that follow, I will show how structural conditions and limitations lead women from different class positions to adopt different modes of action—different forms of agency—with regard to their self-care habits. Furthermore, while Young (1990) suggests that maternal embodiment as a whole has the potential to challenge liberal notions of agency and the self, I find that it is lower-class women whose embodied agency poses the greatest challenge to these notions, while middle-class women tend to back away from this potential, turning instead to more recognizable modes of agency through practices of rigid bodily self-control.

Mothing and Multiple Agencies

Middle-Class Mothers’ Rigid Agency

In describing their actions during pregnancy and thereafter, middle-class mothers in my study often spoke of exercising a rigid control over bodily outcomes and making thoroughly researched choices, both of which fit within familiar tropes of agency. Prior to giving birth, women in this group determinedly pursued the “perfect pregnancy,” reading everything they could and obtaining the services of coaches and specialists to assist them in that pursuit. 32-year-old Stephanie, a White mother living in California, explained, “I wanted to have the absolute perfect pregnancy, because I wanted [my daughter] to have the best start in life...I’ve never been an empty calorie person. But I was much more aware of what I was eating because I was eating

for a purpose.” Drawing on themes discussed in the previous chapter, Stephanie’s description of herself as not an “empty calorie person” tied her body-care practices to her self-identity as a particular type of person. Furthermore, her statement indicated that healthy eating habits were already a part of her pre-pregnancy self-care practices; yet pregnancy required more of her still, such that she would need to improve on her eating habits to achieve “the absolute perfect pregnancy.” Like Stephanie, many other middle-class women spoke to me of their pre-pregnancy self-care habits as a way of foregrounding how they dealt with the bodily changes of motherhood. For these women, the demands of pregnancy—that mothers monitor their eating, exercise in preapproved ways, take vitamins, and avoid “bad” foods and drinks—represented an extension of familiar patterns of dieting and health maintenance, even as the expected bodily outcomes shifted.

Many middle-class mothers dealt with this change by attempting to become experts in their new, unfamiliar bodies. They read about pregnancy extensively, buying such parenting tomes as *What to Expect When You’re Expecting* and reading up on attachment parenting (a time-intensive approach to childrearing popular among many of my middle-class respondents). Mothers supplemented this knowledge by searching the Internet for alternative explanations of and remedies for their bodily discomforts; they also posted questions to online message boards for new mothers. Finally, many went beyond their doctors’ advice and conducted their own experiments to find the body care and nutrition practices that worked best for their bodies. Speaking about her decision to try acupuncture to resolve a chronic health issue, 31-year-old Emily, a White mother from Florida, explained: “It wasn’t that big of a deal, and I didn’t have to worry about long-term consequences. And I figured, well, if it doesn’t work, I’ll be out the fifty bucks per session that I spend, but it’s not going to screw me up.” She read about the procedure online and decided that the risks would be minimal. Similarly, Juana, a 29-year-old Latina mother in California, described how her experimentation with her diet led her to conclude that she was hypersensitive to carbohydrates: “I just started doing trial and error with my own body. I would eat something and then take note of what happened afterward. [Foods that made me feel sluggish] were always carbohydrates.” Although most mothers heeded their doctors’ advice, many, like Juana and Emily, also devoted time to becoming experts on their own bodies. They noted how their bodies felt under varying conditions, then methodically adjusted their self-care practices like laboratory researchers until they reached the ends they sought.

In this way, middle-class mothers in my study conceptualized their bodies as knowable, manageable, and subject to their own autonomous control; in other words, they exemplified traditional notions of agency as self-control while performing neoliberal subjectivities. However, it was during periods when bodies did not behave as expected that the rigidity of these women’s attitudes became particularly visible; for many women, this happened when they attempted to breastfeed. Convinced of the health and development benefits of breastfeeding, most middle- and upper-class mothers in my study at least attempted to nurse. Some found it easy and comforting, and continued breastfeeding until children were 2, 3, or 4 years old. Many more, though, were surprised at how difficult it was; several mothers, when I asked what they would want to tell other women about breastfeeding, gave similar responses to the one offered by Gita, a 27-year-old, mixed-class Indian American mother from California:

I don’t think people were realistic with me about hard it was going to be... It took a lot of time and it was painful. I associated breastfeeding, being able to breastfeed successfully, with being a good mother, and not being able to

breastfeed successfully with not being a good mother. And when I wasn't able to produce enough milk, even after I was taking all these supplements and everything... I had to supplement with formula. I remember feeling like I was not going to be a good mom, because I couldn't breastfeed my child solely.

The experience of having difficulty breastfeeding is not particular to any one class; Gita's response, however, reflected her middle-class upbringing (rather than her current low socioeconomic status, due to being a stay-at-home mother while her husband was a medical student). Steeped in the biomedical vision of a "plastic body" (Bordo [1993] 2003), and confident in her meritocratic belief that self-discipline and hard work could deliver the results she desired, Gita had no notion that her body might evade her control.

Emily described a four-month ordeal during which she developed thrush (a painful yeast infection that can be passed between the breast and the infant's mouth), yet continued pumping her breast milk to give her daughter all the benefits she could. She kept this up until her lactation consultant assured her that it would be all right for her to stop; her husband, however, continued to worry that they were shortchanging their daughter by supplementing with formula, and he suggested buying human milk from a milk bank (at nearly \$5 an ounce) as a "compromise"—the terms under which he would allow her to stop breastfeeding. I witnessed this same dedication when I visited the home of Britta, a White, 35-year-old California mother. Britta and her husband owned a house in a small Bay Area suburb, which also served as Britta's base of operations for her work as a computer technician. Like many of the middle-class mothers in my study, Britta identified strongly with her work, and had managed to convert her job into a consultancy, thereby enabling her to continue her work from home while taking care of her baby. When I arrived to interview Britta, she had given birth to her daughter, Angie, only eight weeks prior. Both were exhausted. Health complications had caused Britta to be hospitalized for a week after the birth, and, as a result, Angie had started drinking formula. Despite this setback, Britta—like many other middle-class women in similar situations—was determined to breastfeed. She had pumped breast milk during her time in the hospital to stimulate milk production, and that milk was then given to Angie in a bottle. Once Britta was well, however, Angie had trouble adapting to the breast. During our interview, I saw the lengths to which Britta was going to develop this "natural" relationship; below is an excerpt from my notes on the encounter.

Britta pulled up her shirt, and with one hand, she attached a breast pump to her right breast. This, she explained, would continue to stimulate her milk production while providing sustenance for Angie to drink later. Then, she lifted Angie to her left breast, hoping that Angie would accept it today. Angie sniffed interestedly at the drops of expressed milk Britta had sprinkled over the nipple, then turned away and began to cry. Undiscouraged, Britta reached over to the side table and picked up a glass bottle full of warm milk, which she had prepared before she sat down with the baby. Coming from the bottle's top was a long, thin, flexible tube. Britta wedged the bottle under her left armpit and placed the other end of the tube across her left nipple. Still pumping milk from her right breast, she returned Angie to the left breast to suck from the tube. The hope, Britta explained, was that Angie would learn to suck on the nipple even as she was getting the predictable milk flow from the bottle that she had come to expect; if all went according to plan,

Angie might someday stop needing the bottle altogether, and be able to nurse from the breast alone.

Throughout this process, I marveled that Britta accomplished all of these tasks with only two hands (to my mind, she needed at least twice that number). I also was struck by Britta's dedication to her breastfeeding goal in spite of the numerous challenges she faced; at some point, might she not find it easier to switch to formula? Like Emily, Britta did not find breastfeeding particularly enjoyable or satisfying, yet she persisted in this task because of her resolute belief in the superiority of breastfeeding; she was able to do so with the support of her spouse and through having a white-collar job that provided flexible hours and the option to work from home.

Children's health was, of course, the primary goal for breastfeeding women like Emily and Britta, but many middle-class mothers mentioned an additional benefit: help with postpartum weight loss. Although breastfeeding mothers had to be careful not to lose too much weight, which could affect their milk supply, many resumed regular workouts shortly after giving birth. Several mothers described the bodily aftermath of pregnancy as being mentally, as well as physically, uncomfortable. Charlotte, a biracial 32-year-old living in California, put it bluntly: "During pregnancy, I remember feeling out of control, like I had lost control of my body. The feeling after I had my baby of wanting to get back to a pre-baby body is totally about regaining control of this body that I feel I've lost control of." 31-year-old Misty, a White California mother who identified herself as an athlete, added, "I was really anxious to get my body back. Because I enjoyed running...and physically exerting myself." And Cass, a 33-year-old White mother from Florida, explained, "I'm at my pre-pregnancy weight, but this is not my pre-pregnancy body...I don't even recognize me when I look in the mirror." Although femininity and sexual desirability played a part in women's post-baby body ideals, women like Charlotte, Misty, and Cass mainly emphasized the ties between bodily control and integrity, thereby displaying the middle-class concern with self-identity and body care discussed in the previous chapter.

Thus, middle-class mothers in my study tended to approach their bodies as malleable projects to be worked on, in line with Orit Avishai's (2007) theorization of "privileged motherhood" and the body. They conducted their own research into self-care techniques and, as well-informed consumers, solicited advice from a range of experts. Ultimately, in their eating habits during pregnancy, their efforts at breastfeeding, and their postpartum weight loss regimens, these mothers modeled the sort of autonomous decision-making and goal-oriented behavior that I term, collectively, *rigid agency*—a mode of action that, contrary to Young's (1990) assertion that privileged mothers are well-positioned to challenge longstanding notions of the self and agency, continues to reflect classical liberal ideals for the autonomous, self-sufficient agent.

Poor and Working-Class Mothers' Flexible Agency

For well-off, well-educated mothers who were more likely to have the means to enact their plans (as well as the culturally conditioned expectation that they would be able to do so), a discourse grounded in *rigid agency* enabled them to assert their own foresight and efficacy, as well as to lay claim to a particularly recognizable form of agency. Yet, as Mahmood argues, the modes of action available to a group—in this case, middle-class mothers—are shaped by the structural conditions in which it resides. Poor and working-class mothers, who face a different set of social structural conditions, are unlikely to have access to the same modes of agency as the middle-class mothers described above. Instead, I will argue for a different mode of agency within this group: what I term *flexible agency*. This form of agency arises from the realization that,

when past experience has shown various life circumstances to be out of one's control, one's time and energy may be better spent adapting to difficult conditions than continuing the stubborn pursuit of one set goal.

In contrast to the type of job flexibility that allowed middle-class mothers like Britta to work from home with their newborns (and to enact particular body projects for themselves and their children), poor and working-class mothers in my study were mainly single mothers working in low-wage positions or enrolled in work training programs. Tina, a 41-year-old Black mother living in California, explained that her job stocking shelves at a grocery store made it nearly impossible to exclusively breastfeed, saying, "I can pump at work, but it's really not realistic to say that I'd be pumping every hour at work." Faced with the "choice" of either quitting her job to attempt breastfeeding at home as a single mother or switching her son to formula, Tina pragmatically opted for the latter. Furthermore, she insisted that this decision was made with full knowledge of the benefits of breastfeeding, saying, "I guess [WIC] figured you don't have the information, so they kind of push it on you. No, it's not that. It's a choice that I've made." Tina's explicit invocation of the language of "choice" was rare among lower-income women in my study; more common, however, was the theme of understanding the supposed benefits of breastfeeding. Similar to middle-class women, many of the poor and working-class mothers I spoke to explained that they had wanted to breastfeed, but ran into pain or supply problems early on. As 20-year-old India, a Black mother from California, described,

I wanted to breastfeed so bad. I was onboard. Like, "Breastfeeding is the way to go." And then, when I had Elle, I could only breastfeed for about a week, maybe a week and four days, that's how long I breastfed her. It was just too painful for me...Everybody had a lot of good things to say about breastfeeding. And I felt like it would have been the right way to go. But it wasn't right for me, at that particular time.

I asked India how she felt about this, and she responded, "I was kind of disappointed in myself. But you know? You can't do everything." As India's story shows, she knew that breastfeeding was supposed to provide the best nutrition for her child, and tried to do what she thought was best. Although she wished she could have continued to breastfeed, she refused to anguish over "failing." Shontel, a Black, 20-year-old mother from California, also tried to breastfeed her son, but after a milk duct infection forced her to switch her son to formula temporarily, she decided to make the change permanent. For Shontel, who was 16 when she had her first child, bottle-feeding gave her the predictability and bodily freedom to continue her schooling and work part-time; importantly, it allowed her mother to share childcare responsibilities. Shontel had given breastfeeding her best shot, but when pain interrupted that plan, she was flexible enough in her plans to try formula, and she found that formula fit her needs even better.

Indeed, few of the WIC-eligible women in my study planned to formula feed from the outset. Most mothers had absorbed the lesson that breast milk was best for their child, and sought to be good mothers by providing that. And they, just like the middle-class mothers I interviewed, sometimes ran into trouble with supply, infection, or pain. The difference was in how mothers from the two groups responded to such difficulties. For middle-class mothers who had a strong cultural investment in achieving their goals and demonstrating their mastery of their bodies, breastfeeding troubles represented just one more physical hurdle standing between them and their aims; their response was to persevere and meet their breastfeeding goals (such as nursing

for a full year). In taking this approach, middle-class mothers acted with *rigid agency*. For poor and working-class mothers, however, *flexible agency* was a more useful and practical approach. Faced with unanticipated problems in breastfeeding, these mothers were not so wedded to the “breast is best” ideology of their higher-income counterparts. Accordingly, they had less to lose by considering formula as a viable alternative. Furthermore, they were more open to considering the positive implications that bottle-feeding could have for their lives. Most WIC mothers in my study were unmarried, and switching their infants to formula allowed them to return to school or work, thereby enabling them to be better providers for their children.¹⁰

Differing structural and socioeconomic influences across classes are, perhaps, most evident in the case of breastfeeding, but they also shaped lower-class women’s health habits in earlier stages of maternal embodiment. Kiara, a Black, 20-year-old Florida mother pregnant with her second child, described her struggles to eat right during her first pregnancy: “I ate a lot of healthy stuff—fruit, vegetables. I snuck out and ate a couple of times. I always had a craving for pizza, but after I ate pizza, I’d eat something healthy.” Her second pregnancy, however, was not going very well. This pregnancy was both unplanned and medically inadvisable, as Kiara had been recently diagnosed with a serious heart condition. By the time she realized she was pregnant, though, it was too late for her to terminate the pregnancy. Between caring for her three-year-old and her heart problem, Kiara was always tired, and she had lost all hope of having a “healthy” pregnancy. These difficulties were compounded by Kiara’s lack of social support. Although she lived with her mother, she described the household as an additional source of stress, short on money and overrun by the younger siblings and cousins her mother looked after. Even though she knew that salty, fatty foods were, in her words, “bad,” she ate them for the comfort they offered. Forty-five-year-old May, a Black mother in Florida, added that making the dietary changes her WIC counselor recommended was particularly difficult, saying, “I didn’t want to eat no fish, no carrots, no nothing like that. But I had to because I wanted my baby to come out healthy. And he did come out healthy.” Nicki, a White, 30-year-old Florida mother, noted that she was generally “a pretty lousy eater” but added, “Well, when I’m pregnant, I eat better.” May and Nicki both echoed a common trend among poor and working-class mothers in my study. Healthy eating all the time might not be possible, but they tried to make improvements in their diets when they thought it would matter most.

Several other low-income women were less concerned with their prenatal diets; instead, they emphasized the importance of eating well and setting a good example for their children later on. Thirty-two-year-old Frankie, a White mother from Florida, explained why cutting unhealthy foods out of her diet was important, saying, “My little girl wants to eat whatever she sees somebody else eating. We could be at a football game and if she sees nachos, she’ll want nachos.” Thus, rather than treating healthy eating as a lifelong body project, low-income women in my study adopted it selectively, investing their effort when they thought it would yield the greatest reward.

When I asked 19-year-old Mercedes (a Latina mother living in California) about whether she had made any changes in how she ate or cared for her body during pregnancy, she responded, “Not really, because I found out when I was four or five months [pregnant]. And I didn’t gain

¹⁰ Research by Dawn Dow (2011) shows that working for pay is part of a particularly racialized ideology of motherhood. Whereas the “mommy wars” pose a tension between “good” stay-at-home mothers and “bad” or selfish working mothers, Dow suggests that this tension is not universal. Looking at the choices made by middle-class Black mothers, she finds that these women view work as a key component of good motherhood, writing that they believe “working is a duty of motherhood” (p. i).

any weight, whatsoever. I didn't have any cravings, any nausea, any symptoms at all...I couldn't really tell, until just out of curiosity [I took a pregnancy test], and I was like, 'Crap, I'm pregnant!'" Mercedes' admission that the pregnancy took her by surprise was one way in which she—and other lower-class mothers I interviewed—used rather different language to narrate their stories than that of middle-class mothers. Almost certainly, women of both classes sometimes found themselves unexpectedly pregnant, and those women made choices in the face of such surprises. However, middle-class mothers tended, in their self-narratives, to take particular credit for the choices they had made, while women like Mercedes tended to acknowledge the circumstances beyond their control.

Mercedes went on to describe the sequence of events that led to her current situation: living with her boyfriend's family and raising her nine-month-old son. After she learned of her pregnancy, Mercedes and her boyfriend became engaged, and she moved in with him, his parents, his two older siblings and their families. When she was seven months pregnant, her father was sent to prison, with the threat of deportation after he served his sentence; Mercedes' mother and younger siblings moved several hours away to live with other family members. Only a week later, Mercedes went into premature labor and delivered her son. I commented that it seemed she'd found a more stable situation with her in-laws, but Mercedes corrected me on that point: her father-in-law had lost his job in the recent economic downturn, and the house was now facing foreclosure. She did not know where she would go if they lost the house.

Despite these stressful circumstances, Mercedes endeavored to exercise and eat the sort of low-fat diet she thought would help her shed the "baby weight." Describing a friend who supported her in these efforts, Mercedes said, "I always go for walks with Anita. She tells me, 'Let's go to the gym.' But I'm not a member, so we just go for walks." Mercedes could not afford the gym fees, and she even if she could, she would have had to find a babysitter for her son. Under those conditions, she attempted to get in shape the best she could.

Mercedes' options for postpartum fitness were limited by her finances, a common theme among poor and working-class mothers I interviewed. Yet, while many were dissatisfied with how pregnancy had changed the shape of their bodies, not all had Mercedes' familial resources (such as the aid from her fiancé and future in-laws that allowed her to focus on her own health and her son's). As such, still more women described the changes in their bodies with a tone of resignation. Twenty-six-year-old Becky, a White mother living in California, explained, "I was feeling something was wrong with my body. I just wished I was a little bit—not as big as I was, you know?...It was embarrassing to me. But it all comes with having a child, so you just learn to deal with it." Shontel reflected on her post-baby body and said, "It's not how I really want to look. I want something different, but everybody does." In phrasing her complaint thus, Shontel simultaneously named and downplayed her dissatisfaction; her unspoken assertion was that deeply wanting something was not enough to achieve it, especially when she faced so many other demands on her attention. Twenty-one-year-old Sarah, a White mother living in Florida, described her efforts to balance weight loss, raising a child, and going back to school, saying, "It's hard to remember that you have to eat this and eat that. I can stay on a diet, it's just that when you get so busy...you forget." And 28-year-old Paz, a Latina mother in California, explained, "I feel fat. Because the babies are too little now, and I don't have time for doing more *ejercicio*." She added,

I have nine-month-old twins, and it's a 24-hour job. Normally, I got to feed the babies, change the diapers. All night, no sleep too much. I drink like five or six

cups of coffee every day to stay awake for the kids...I'm so busy! And sometimes I no have time to eat. Or...I don't have time in the morning and I only eat at twelve, one, or later.

Public discourses about poor and working-class women tend to frame them as making bad choices for their bodies, often due to a lack of knowledge or, as suggested by the 1965 Moynihan Report, because of faulty values: the so-called “culture of poverty.” Yet, my interviews with these women show that they shared many of the same values and hopes as middle-class mothers, but with far fewer resources for attaining those goals. It is important to keep these structural constraints in mind when examining poor and working-class women’s self-care practices. However, such structural analyses do subjects a disservice if they do not also consider other modalities of action besides the autonomous, goal-driven agency that typifies my middle-class respondents. In the face of uncertain life circumstances, poor and working-class women I interviewed juggled their responsibilities, often very deftly. When something did not go according to plan, they responded with *flexible agency*—that is, they quickly adjusted their course of action, letting go of one expectation and moving on to the next, working within constraints to effect whatever change they could in themselves and the world around them. In this way, their stories reveal the particular mode of action—the type of agency—that is commonly available to poor and working-class U.S. mothers.

The Best-Laid Plans: When Physical Complications Create Complications in Agency

The terms *rigid agency* and *flexible agency* characterize the general patterns of action (and justification for action) I observed among middle- and lower-class women, respectively, but they were not absolute. Given the ties between modes of agency and the structural conditions—material, historical, cultural—in which women reside, it stands to reason that certain situations might arise in which women adopt forms of agency otherwise unusual for their class position. As noted earlier, middle-class women are sometimes forced to reconcile their ideal of breastfeeding with the realities of bodily or other situational limitations, eventually giving up or compromising their original goal. This phenomenon constitutes a discrete instance of middle-class flexible agency, though incomplete: middle-class mothers often reached this juncture only after considerable physical difficulty and mental anguish, and though they might learn flexibility from the experience, they still tended to strive for control in other areas of their lives and to craft their stories in ways that emphasized their conscious self-control and decisionmaking. In contrast, lower-class women faced many of the same bodily challenges during breastfeeding, but were more accustomed to reconciling themselves to circumstances they could not alter. Given the extent to which childbearing and childrearing entail circumstances beyond one’s control—and, thus, a need for flexibility—might lower-class women have an easier adjustment to motherhood? Furthermore, how might lower-class mothers’ structural location enable them to more fully embrace the alternative forms of agency revealed by maternal embodiment?

Several middle-class mothers spoke about instances in which they had ceded a measure of control and learned to be more flexible, often tying this skill directly to the demands of new motherhood. Amy, a middle-class, 35-year-old Chinese-American mother in California who repeatedly referenced the need for mothers to accept a certain loss of control, described how difficult it was for her to adopt that mindset once she became a stay-at-home mother: “I came from corporate background, where everything was very black-and-white, very succinct and orderly. And then when kids came along it totally turned my world upside down.”

Thirty-three-year-old Bree, a White mother from California, cultivated a flexible mindset by enrolling in prenatal classes premised on the Buddhist practice of “mindfulness,” which she described as a combination of planning and flexibility: “It’s not trying to control every aspect of your child’s birth—[it’s] having a plan and going into it mindfully.” The birth plan Bree spoke of (and which her mindfulness practice taught her to soften) was a strategy many middle-class mothers undertook in hopes of retaining a measure of control over one of the most potentially out-of-control-seeming experiences of maternal embodiment: childbirth. Social critic Naomi Wolf (2001) describes the promises and pitfalls of the document thus:

Hospitals and obstetrical practices that deal with demanding clients such as our educated cohort encourage couples to write such a plan, as it gives us a sense of consumer choice. We are not told outright that it is hospital protocols that determine what will happen in the course of delivery, usually regardless of what one’s plan might say...The joke is that you would believe that you have any power in the hospital to change the outcome. (p. 86)

Similar to Wolf, many middle-class mothers in my study did extensive research about how to have the “best” childbirth experience; “natural” (non-medicated, vaginal) childbirth was often idealized, for both for its supposed health benefits and the greater degree of control it offered mothers over their bodies. Also like Wolf, these women sought to retain control in childbirth through their choices as consumers in the obstetrical market. Particularly in California, women staffed their deliveries with midwives (believed to impose fewer unnecessary medical interventions) and doulas (nonmedical personnel who support women through labor, often enlisted to advocate for mothers’ plans in hospital settings). Despite these well-laid plans, however, childbirth often did not go as expected. Complications during pregnancy sometimes foiled mothers’ hopes for home births, and difficult labors often were remedied with labor-inducing drugs and painkillers. Bree, for example, ultimately assented to her obstetrician’s suggestion that she take drugs for the pain. She credited this adaptability to her prenatal cultivation of mindfulness: “The one thing I learned...was, you need to be flexible. And that if you hold on to something rigidly—anything—and then it goes differently, it’s very hard to get over that.” Essentially, Bree had incorporated a small measure of flexible agency into her rigidly agentic outlook, using it to help her negotiate not financial limitations on her choices, but bodily ones. However, lest this perspective be taken as passivity and inaction, Bree carefully reframed it as evidence of her intentional, agentic preparation for becoming a mother.

Suzanne was an athletic, 35-year-old White woman in California who had planned on having a “natural” childbirth. However, after her labor stalled, her caregivers recommended an epidural anesthetic and medications to induce contractions. Suzanne hesitated at first, but then relented. She told me, “At one point I was like ‘Giddy-up! Giddy-fucking-up. I’m in this. My plan is so out the window.’ And I was fine with it. Whatever is happening is happening.” Hours later, the medications began to wear off, and she grudgingly agreed to a second epidural. Even as she consented, Suzanne hoped to regain bodily control, explaining, “I had a thought in my head: ‘I’m not going to get it [the epidural] again.’ I had a lot of faith in my body. So by five p.m., just as the anesthesiologist was walking into the room, the nurse checked me again...I was at ten [centimeters—fully dilated and ready to give birth]. Just as this dude [the doctor] was walking in the room. And I was like, ‘I’m not getting an epidural!’” Suzanne temporarily relinquished her rigid control over her body, a flexibility that gave her a brief respite from the pain of childbirth

and allowed her to rest. However, the familiar urge to control her body reappeared before long, and Suzanne completed her labor “naturally,” thereby reclaiming the sense of self with which she identified.

Few middle-class women shifted between flexible and rigid agency so quickly, but many did seek to reassert the type of rigid self-control traditionally associated with agency soon after giving birth, or, as Bree did, to narratively frame their pliancy as part of a calculated plan for self-improvement. By contrast, stories about control and loss of control in the delivery room were practically nonexistent among lower-income mothers in my study.

I should note that my initial interview guide did not include questions about these subjects, because I aimed to study the practices of self-care these women cultivated in their day-to-day lives, rather than the acute conditions they faced during labor. Nonetheless, childbirth became an emergent category in my analysis as numerous middle-class mothers volunteered their stories; clearly, for these women, it posed a critical challenge to preconceived notions about bodily integrity and self-control. Indeed, as such stories make plain, childbirth (and, to some extent, breastfeeding) is among the most idealized venues for self-management, but it is also an arena in which bodily self-determination is most elusive. Both the physical realities of childbirth, which sometimes necessitated medical intervention, and the legal and medical norms observed by hospitals structured a setting in which middle-class mothers were less likely to have the control they desired. As a result, these women found themselves forced to adopt a measure of flexibility (which, to some, felt like a *loss* of agency and a threat to self-identity).

In contrast to middle-class mothers like those described above, few poor and working-class women volunteered stories about their childbirth and delivery experiences. Margaret Nelson (1982) describes one reason this might be: “[Working class women] are less likely than middle class women to favor a natural childbirth, to plan for each stage of the birth process, and to prefer giving birth without medical intervention. During the birthing itself, working class women experience more medical intervention and less active involvement in the birth process” (p. 349). Given lower expectations about being intimately involved in each step of labor and delivery, it seems likely that lower-class women did not experience it as a key site in which their agency or sense of self would be called into question.

Nelson adds that while middle-class mothers are more likely to be committed to natural childbirth, lower-class women “remain unconvinced about the merits of this particular birth style” (p. 344). Ellen Lazarus (1994) agrees, describing her finding that middle-class mothers sought control over the process of pregnancy and childbirth (often by recruiting a physician to be their advocate). Other subjects in Lazarus’ study, middle-class mothers who were also health professionals, “used their knowledge of the health system as a way of maintaining that control.” In contrast, “[p]oor women neither expected nor desired control but were more concerned with continuity of care” (1994: 25). Mothers in my study adhered to these patterns closely; the lower-income exceptions occurred among mixed-class WIC recipients. Dani, a White, 24-year-old mother from Florida, was one such exception. Dani told me about how she planned for a “natural” childbirth but ended up needing a Caesarian section at the last minute, commenting, “I was kind of bummed about that...’Cause I had a plan.” I asked why she had hoped to deliver in a natural birth center, and she responded, “I have a really high pain tolerance, so I wanted to test myself and see. You know, if I can’t handle it, I’m not going to be mad at myself. [I] could ask to go to the hospital.” Even though Dani was frustrated about her lost opportunity to “test” herself in this way, her subsequent comments revealed that she would have been open to hospitalization if need be. Dani’s plan—unusual among WIC recipients—would appear to be a product of several

circumstances. On one hand, she lived in a community with a natural birth center and a number of certified midwives, meaning that she may have had greater than average access to information about this type of labor and delivery. On the other hand, Dani came from a decidedly mixed-class background. While she currently lived with her welfare-reliant mother, Dani had spent periods of her childhood living with her middle-class father out of state. Furthermore, her father continued to send Dani money, and he had contributed directly to her prenatal care expenses, even paying for a medically unnecessary three-dimensional ultrasound to assuage Dani's worries about her baby's development. In other words, she had both exposure to middle-class cultural norms of the body in general and the financial means to explore alternative ways of cultivating her maternal body. Yet, with her remark that she "wouldn't get mad at [herself]" if her plan did not work out, Dani took this possibility in stride with considerably more grace and flexibility than many of her middle-class counterparts who voiced a similar plan.

Discussion and Conclusion

In this chapter, I begin from Iris Marion Young's (1990) premise that maternal embodiment carries the potential to challenge classical norms for bodily autonomy and agency. New physical goals in women's self- and child-care practices—and intense, contradictory social norms regarding what those goals are and how they should be pursued—require a degree of personal flexibility that runs counter to the neoliberal vision of agency in which one strives to maximize one's own interests rigidly, at all times, and without compromise. Indeed, most women, regardless of class, experienced the need to act with a more flexible type of agency at some point during the transition to motherhood. How they responded to this situation, though, differed substantially. Most middle-class mothers did not appear wholly comfortable with this type of adaptability—they tended to treat it as a temporary concession, and they often worked to assert more familiar forms of agency, autonomy, and control (sometimes, as with Charlotte and Suzanne, as soon as their bodies would allow). Even middle-class women like Amy and Bree, who recognized the need for flexibility, maintained a tie to more recognizable forms of autonomous subjectivity and rigid agency through the narrative approaches they took while telling me their stories. Bree explained that flexibility was part of a practice she had actively sought out and cultivated in preparation for motherhood; Amy, too, described her flexibility as hard-won, contrasting it the high-powered, corporate career she had left voluntarily (thereby asserting this as a choice, not a failure).

Past studies have shown how women who accept the terms of a patriarchal society may, in certain circumstances, stand to gain—a phenomenon Deniz Kandiyoti (1988) has termed a "patriarchal bargain." Critically, Kandiyoti demonstrates that situational constraints may make certain women more or less likely to accept or to resist such a bargain, "which may exhibit variations according to class, caste, and ethnicity" (p. 275). She adds that "[p]atriarchal bargains do not merely inform women's rational choices but also shape the more unconscious aspects of their gendered subjectivity" (1988: 285). In the context of maternal embodiment and subjectivity, I would suggest that middle-class women stand to gain the most by rejecting the alternative forms of agency opened up by their experiences as new mothers. Within a neoliberal society that primarily rewards agency in its most autonomous and rigid form, middle-class mothers' patriarchal bargain requires them to maintain a near-superhuman control over their personal and professional lives in order to be recognized as fully agentic subjects.

That control, however, is facilitated by these women's social and material resources. For poor and working-class mothers I interviewed, maintaining such a high degree of control over

the body—and investing so much of one’s self-worth in that control—was practically unthinkable. In popular discourses, this state of affairs has been ascribed to poor mothers’ lack of agency or, on a related but slightly more generous note, their lack of knowledge. In this chapter, drawing on Saba Mahmood’s call to explore “other modalities of agency” (p. 153), I have striven to map out what I call *flexible agency*, a mode of action for navigating limited options that relies on adapting to—and working around—physical and social structural impediments, rather than rigidly exercising one’s will (and one’s wallet) to push through those barriers. Flexible agency is not about ceding all control over one’s body and life; rather, it entails an intentional process of picking one’s battles and cultivating a resilient self (one that is not thrown into crisis by structural or bodily setbacks while pursuing one’s goals). While such flexibility was sometimes imperative for all mothers, it was, contrary to Young’s (1990) prediction, poor and working-class women who seemed best equipped to exercise it.

Thus, I suggest three major conclusions and areas for further research. First, drawing on the theories of Saba Mahmood and Iris Marion Young, I assert that maternal embodiment across classes allows us to see two distinct modes of agency: *rigid agency*, most prevalent among middle-class mothers and aligned with classical conceptions of agency, and *flexible agency*, more common among poor and working-class women and entailing adaptability and a calm readiness to work around situations beyond one’s control. Second, attending to these multiple modes of agency prompts the realization that recognizing agency only in women’s deliberate decisions and carefully considered behaviors means privileging the modes of action in which middle-class women engage, thereby reproducing moral discourses about “good” middle-class mothers and “bad” poor and working-class mothers. Third, rigid agency is revealed as part of the patriarchal bargain that middle-class mothers attempt to strike, even when it is sometimes incompatible with the practical and embodied challenges of motherhood. This tension can be seen in the contemporary (middle-class) “mommy wars,” the anguished efforts with which professional women attempt to be “supermom” or to “have it all.” If, as Young suggests, maternal embodiment enables us to imagine a self and a way of being in the world not premised on rigid, air-tight control and personal autonomy, it is in poor and working-class mothers’ actions that this alternative mode of agency can be seen most clearly. Indeed, while feminist researchers and activists have focused on one side of the equation, working to alter social and material conditions to equip disadvantaged women to make choices about their bodies, I suggest that we should not neglect the lessons such women can offer. Ultimately, normative rigid agency reflects not only the freedom to make choices in one’s life, but also the imperative to be constantly in control; when such control is neither possible nor desirable, it is poor and working-class mothers who best model the resilience needed to keep going.

CHAPTER FIVE

Class Futures and Babies' Bodies: Embodied Status Transmission in Early Childhood

The previous chapters have focused on middle- and lower-class women's care of—and feelings toward—their own changing bodies during and after pregnancy. I show how, overlaid on an essentially “natural” biological phenomenon that poses the same range of physical challenges and rewards to all mothers, classed material and cultural distinctions between women lead to starkly divergent experiences in the transition to motherhood. Highly stratified according to class, new and expectant mothers learn about the “right” way to care for their bodies from different sources (government programs like WIC, individualized research projects), with differing access to resources that might help them succeed in their pursuit of these bodily goals, and with divergent potential consequences for success or failure (recognition as neoliberal citizens, status and support vis-à-vis other mothers, and differing levels of recognition as agentic actors and “good” mothers).

In this chapter, I turn from the attitudes and practices mothers cultivate for themselves to their aspirations for the health and bodies of their children. Indeed, children's wellbeing is the most commonly cited target of mothers' body cultivation practices, even when, as I have detailed in the previous chapters, those practices also have consequences for mothers' own health, sense of self, and social standing. Here, I suggest that mothers' prenatal and early childhood cultivation of their children's bodies merits further attention, not merely for the health of future generations, but to understand that project as a key site of early status transmission from one generation to the next.

On one hand, class and health in childhood have been shown to be linked, with poor and working-class children more likely to suffer from chronic illnesses like asthma (Nikiéma, Spencer, and Séguin 2010), and they have “higher rates of hospital admissions, disability days, and death rates” than non-poor children (Wood 2003: 709; Dawson 1991). While many of these class-linked conditions can be attributed to environmental factors (Eggleston 2000), some are tied to a lack of preventative care and to nutritional deficits in poor and working-class people (Halfon and Newacheck 1993; Heinzer 1998; Jeng et al. 2009). Indeed, WIC was established in part to monitor poor children's health and to provide for baseline standards of nutrition to combat various childhood ailments. Hunger and chronic illnesses can cause children to perform poorly in school, and may form an indirect means by which children from lower-income households are disadvantaged in their educational and career pursuits in later life.

On the other hand, as David R. Williams and Chiquita Collins (1995) find in their review of studies on the link between poverty and illness in adults, ill health is more often a symptom than a cause of poverty; as such, it is a reflection of poor children's class background, but it is not the primary means of bodily status transmission from poor parents to their children. Instead, given the neoliberal moral valuation of health (or, perhaps more importantly, the pursuit of health) and self-discipline, I argue that mothers' early lessons to their children about food, exercise, and self-care may constitute an emerging mode of class cultural transmission.

Culture, Care, and Status Transmission

In the context of the American democratic state, which has no legal caste system and in which individuals are formally free to pursue whatever occupations they wish, sociologists have

sought to understand the persistent structural and informal barriers to social mobility. Much of this inequality is tied to material wealth or deprivation and a pattern of residential segregation that results in areas of highly concentrated poverty or affluence (Massey and Denton 1993). Alongside these accounts, however, a number of scholars also highlight the role played by culture to explain, in the words of Paul Willis ([1977] 1981), “how working class kids get working class jobs.”

For Willis and many others, the key site for studying these cultural processes is school, where children go to prepare for adult life (and which, in liberal democratic tradition, is seen as the “best hope for leveling class differences” [Aronowitz 1981]). According to this vein of thought, the cultural values most salient to class mobility or reproduction are those that impact children’s success in the classroom. Willis, who studied working-class “lads” in an English secondary school, observed that these boys cultivated an oppositional attitude toward school. Frustrated by the disadvantage bestowed by their families’ working-class backgrounds, the boys developed a culture of rebellion against school discipline that, in turn, led them back toward low-wage labor. In contrast, middle-class parents tend, to a greater degree, to instruct their children on the importance of academic success. Michèle Lamont and Mario Luís Small (2008) explain that “middle and upper-middle class adults (professionals and managers) pass on advantages to their children, mostly by familiarizing them with cultural habits and orientations valued by the educational system” (p. 86). Contemporary studies of culture and class reproduction do not espouse the “culture of poverty” approach that judges poor and working-class people’s values as deficient; rather, they show how various social institutions, particularly schools, are set up to recognize and validate the cultural knowledge of middle-class people.

While much of the scholarship in this area focuses on the actual school setting, Annette Lareau’s book, *Unequal Childhoods* (2003), stands apart by looking at family life, asking how children come to possess the particular values and habits—the class *habitus*—that they then bring with them into the classroom. In her study, which examines status transmission and cultural capital among families with 9- and 10-year-old children across class and racial/ethnic backgrounds, Lareau identifies two distinct patterns of childrearing. In poor and working-class families, parents employ what Lareau calls the “accomplishment of natural growth.” Children in these families have ample time to play by themselves and with other children, and have relatively few structured activities—they are, in other words, left to their own devices to grow “naturally.” In middle-class families, parents instead engage in a set of practices Lareau terms “concerted cultivation.” Here, parents actively and unceasingly work with their children to develop language skills, inquisitiveness, school achievement, and physical fitness. Children in these families have fewer unstructured periods of time in which to play and be creative with peers, more structured activities, and more interaction with adults. Lareau notes that both concerted cultivation and the accomplishment of natural growth have their own benefits to children and families; however, the middle-class families’ concerted cultivation approach is more aligned with expectations of the school environment. This helps to set those children up for a smoother transition to school, an easier time understanding what is expected of them there, parents who have more resources to work with teachers, and a sense of greater entitlement to ask for help or accommodations to help them succeed. Lareau concludes, “differences in family life lie not only in the advantages parents obtain for their children, but also in the skills they transmit to children for negotiating their life paths” (Lareau 2003: 749).

In her attention to parenting practices, class cultures, and intergenerational status transmission, Lareau provides an important reference for this chapter. At the same time, I

diverge from her analysis in a couple of key respects. First, where Lareau looks at the parenting practices of families with 9- and 10-year-old children, my project extends further back, charting the path of class cultural transmission from the womb through early childhood. This difference is tied to the divergent aims of our projects. Lareau studies school-aged children because of her particular interest in the ways that home life affects children's attitudes toward—and success in—school. Specifically, she asks how class differences in *habitus* and *cultural capital* (both concepts drawn from Bourdieu) “give individuals varying cultural skills, social connections, educational practices, and other cultural resources, which can then be translated into different forms of value (i.e., capital) as individuals move out into the world” (2003: 276).

In many ways, this chapter asks the same question of the women and children in my study—how do women across classes seek to instill particular body care skills and values in their children, and with what potential costs or benefits to children in later life? But where Lareau attends mainly to the intellectual and attitudinal components of cultural capital and the *habitus*, my focus is on their bodily aspects. Lareau draws heavily on the work of Pierre Bourdieu, yet she disregards Bourdieu's insistence that elements of the *habitus* are acquired not only cognitively, but physically: *habitus* is literally embodied. This view is expressed clearly by Loïc Wacquant (2004), who explains that to become habituated is to “modify one's bodily schema, one's relation to one's body and the uses one usually puts it to, so as to internalize a set of dispositions that are inseparably mental and physical” (p. 95). While Wacquant is speaking about the work of learning a new physical skill—boxing—as an adult, many such “inseparably mental and physical” dispositions are learned during the earliest years of childhood. As my conversations with new mothers reveal, women think about such bodily habituation quite early, often when their children are still infants and toddlers.

A final difference between Lareau's work and my own is the question of where and when certain forms of cultural capital may be recognized and converted into other types of value. While school provides the institutional setting in which many aspects of cultural capital are translated into tangible advantages (or disadvantages), such is not the case for all cultural capital. Beyond schooling, class-conditioned habits may help middle-class jobseekers gain access to favorable positions; Michèle Lamont, speaking of white-collar workplaces, explains that “managers favor employees who resemble them culturally, and...corporate success partly depends on making other managers ‘comfortable’ by conforming in cultural matters and not ‘standing out’” (1992: 1). How, then, do parents prepare their children for success in this milieu? According to Bourdieu, “members of the professions...invest in their children's education but also and especially in cultural practices which symbolize possession of the material and cultural means of maintaining a bourgeois life-style and which provide a social capital, a capital of social connections, honourability and respectability that is often essential in winning and keeping the confidence of high society” ([1979] 1984: 122). Likewise, turning to class cultural norms about the care of the body, I will attend not only to the pragmatic reasoning that many mothers cite (namely, that particular practices will benefit the child's health), but also to underlying cultural meanings of those practices. Such meanings position those with the correct habits as moral, neoliberal actors and create, among people who share these habits, an unspoken dimension of mutual understanding and recognition.

The existing literature does not adequately address these issues in the specific case of early childhood body cultivation and status transmission, although it does provide some clues as to possible class differences. As with many other childrearing trends, middle-class parents have tended to be among the earliest adopters of new techniques in child care and feeding (Lareau

2003), a pattern that seems to hold true in the earliest years of life. As Rima Apple (1987) explains, when doctors began to develop and market commercial infant formula as a substitute for breast milk in the late nineteenth century, it was middle-class mothers who first popularized its use. On one hand, this had to do with economic means: formula cost money, whereas breastfeeding did not. On the other hand, middle-class families' adoption of formula also reflected class cultural concerns. At the time, the healthiest alternative for babies without lactating mothers (due to maternal death, absence, or insufficient milk production) was to hire a wet nurse to breastfeed the child, generally a woman of lower class origins. Still, families—and mothers in particular—worried about the effects of wet nurses' lifestyles and diets on their charges, a concern one ladies' journal editor ascribed to the fact that “wet nurses are not selected from the highly-intelligent classes” (Apple 1987: 15). Furthermore, formula fit with the era's ideology of “scientific motherhood,” described by Apple (1995) as “the insistence that women require expert scientific and medical advice to raise their children healthfully” (p. 162). According to this logic, women were still “naturally” responsible for the health and development of their children (whereas men were not), but they could not rely on instinct or tradition alone; rather, “good” mothers would manage the day-to-day business of childrearing while modeling their practices on the advice of (male) scientific authority. A scientifically validated formula that reassured women that their children were receiving the proper nutrients and made it possible to measure and monitor infants' daily intake fit into this ideology neatly. Thus, breastfeeding in the late nineteenth and the first half of the twentieth century was weighted with class politics: middle-class, White women who could afford formula upheld it as the most modern, scientific (and thus, “good”) way to feed a baby, while poor and working-class mothers—and, usually, racial/ethnic minority women—were positioned as more “natural” mothers: less scientific, less cultured, and even more animalistic in their infant feeding “choices.”

Around the middle of the twentieth century, however, cultural discourses around infant feeding shifted once again. In the 1960s and 1970s, breastfeeding gradually came back into vogue, particularly among White, class-privileged mothers. Bolstered by feminist health activism (which rejected political and medical attempts to control women's bodies) and maternalist groups like La Leche League (formed by a group of progressive middle-class Catholic housewives in Chicago), breastfeeding gradually came to be seen as the enlightened choice for modern mothers. Once again, White, middle-class women led the way in (re)adopting breastfeeding and shifting its cultural meaning. At the same time, given long-lived cultural denigration based partly on their alleged closeness to nature, poor women and women of color may have had well-founded concerns about a practice whose benefits were based on a claim to being “natural.”

Evidence from the historical case of breastfeeding supports two conclusions. First, while virtually all mothers hope to give their children the best possible start in life, the criteria for what that entails are often uncertain. Second, given the ever-changing state of best childcare practices, it is middle-class women who are best able to keep up; perhaps less relevant than the content of those practices is the fact that middle-class subjects tend to stay on the cutting edge, thereby displaying their early adoption of new childcare techniques as evidence of their knowledge and worth. Indeed, these subjects' ability to incorporate new health practices swiftly may be the most uniquely middle-class part of their health culture. With these considerations in mind, I ask: how are the mothers' embodied child- and self-care practices not only reflective of class, but actually *constitutive* of it? Specifically, in what ways do mothers' efforts at bodily cultivation position

their children for future lives as classed subjects by transmitting bodily privilege or disadvantage and imparting embodied cultural knowledges?

Findings

The mothers in my study expended considerable time and energy during pregnancy and thereafter to make the right choices for their own bodies and those of their children. Even as they strove toward health, the ways in which they did this—and the lessons they hoped to teach their children about health—carried class cultural meanings. Unlike previous chapters, in which middle- and lower-class mothers' accounts of their own self-care practices, and the structural support they received for these, were sometimes strikingly dissimilar, I often found it difficult to discern strong class patterns in their aspirations for their children's health and self-care practices. Nearly all mothers hoped that their children would love, honor, and accept their own bodies, and that they would learn to enjoy exercise and healthy foods so that good health would come easily. And yet, mothers had vastly different resources with which to cultivate these qualities in their children, and their specific beliefs about which foods were “good” and “bad” also tended to follow classed patterns. Critically, middle-class mothers asserted less that their children should follow any particular diet or exercise plan—although they did offer plenty of these—and more that they hoped to teach their young children to become informed consumers. While this attitude may reflect, in part, the recognition that scientific and medical opinions regarding best health practices are constantly changing, and that children will need to keep up, I suggest that it also reveals the way in which health and body care are markers of status. As Lareau explains about status transmission and education, “any effort to spread an elite practice to all members of the society would result in the practice being devalued and replaced by a different sorting mechanism” (2003: 277). Likewise, as one idea about self-care becomes widespread, another quickly replaces it as the “best” practice. It is through their early socialization in self-care and informed consumerism that middle-class children grow to become the early adopters of these techniques, while lower-class individuals appear to lag behind, never taking adequate care of themselves and, in popular discourse, becoming a drag on public health resources. Ultimately, this process of constantly moving the bar for “good” motherhood and health practices becomes a means by which middle-class mothers, whether consciously or inadvertently, maintain status for themselves and transmit it to their children.

Cultivating Prenatal Development

For the majority of women I interviewed, biomedical projects of risk management and health optimization for their children began during pregnancy. In some part, these projects were tied to growing public awareness, in the last half century, of the various dangers that fetuses may face in the womb. In the early 1960s, the highly publicized birth defects caused by thalidomide, a drug prescribed to alleviate morning sickness in pregnant women around the world, led to greater scrutiny of the use of various prescription medications and treatments on pregnant women. The 1980s brought heightened attention to the potentially fetus-endangering practices of U.S. mothers themselves, with moral panics over drug-addicted newborn “crack babies” (Roberts 1999) and the introduction of alcoholic beverage labels in 1988 to educate pregnant women of the dangers of fetal alcohol syndrome (Hankin, Sloan, and Sokol 1998).

Alongside these very real concerns about fetal risk, however, is the increasingly biomedicalized practice of viewing the fetus as an independent patient (Petchesky 1987; Pollitt 1990; Wolf 2011) and the prenatal period as a time ripe not only for risk prevention, but for

health and future lifestyle optimization. This view is epitomized by a September 22, 2010 *Time* cover story on the “fetal origins” of human health and behavior. In the provocatively titled article, “How the First Nine Months Shape the Rest of Your Life,” author Annie Murphy Paul reviews a growing body of research on how various aspects of the prenatal environment can have significant effects on one’s life later on, shaping one’s chances of having a high IQ, becoming obese, experiencing mental illness, or developing heart disease. Signaling the shift from medical to biomedical perspectives on fetal health, Paul writes, “The scientists I met weren’t full of dire warnings but of the excitement of discovery... We’re used to hearing about all the things that can go wrong during pregnancy, but as these researchers are finding out, *it’s frequently the intrauterine environment that makes things go right in later life*” (Paul, September 22 2010, emphasis added). In some sense, Paul’s comment here sounds like a question of semantics; if researchers find, for example, that reducing maternal stress during pregnancy can lower a child’s risk of becoming overweight, then it may be only a matter of time until pregnant women are routinely warned that high-stress lifestyles could endanger their unborn children. At the same time, the distinction Paul makes is the difference between an earlier era of medicalized understandings of pregnancy (treating ill health, minimizing known dangers) and biomedicalized ones. In the biomedical perspective, the aim is to optimize maternal and child health to ensure that “things go right in later life.” In point of fact, biomedical “fetal origins” research provides no guarantees of good health for a child, but, rather, a somewhat speculative assessment of a child’s relative *risk* of developing various health conditions or of failing to reach its full potential. As Joan Wolf (2011) observes, no pregnancy is free from risk. Instead, all pregnancies are classified according to their *degree* (high or low) of risk to the fetus.

Meanwhile, as fetal health has become the target of biomedical risk discourse, mothers have been repositioned from patients to, in Paul’s words, an “intrauterine environment.” By nearly all accounts, mothers’ needs are expected to come second to those of their children. No longer is it sufficient to minimize quantifiable harms to the fetus or newborn, avoiding known hazards such as environmental toxins or certain illicit and prescription drugs. The responsible mother must now tailor her lifestyle to create an optimal environment for fetal development, aiming to maximize a number of relatively unproven benefits through careful monitoring of her own diet, exercise, and even emotional state.

This biomedicalized, child-before-self mindset was espoused by most women in my study, both lower- and middle-class. As many reasoned, what mother would not weather some discomfort or inconvenience to provide her child with the best possible start in life? Cass, a White, lower-middle-class mother in Florida, explained:

For me, it was just a no-brainer ... I read up about the foods I should be eating, took my prenatal vitamin religiously (and I know a lot of women say they stop taking theirs after the first trimester). I completely avoided Cokes, even though I was dying to have one some days, because I was so tired in the first trimester. But to me, it was just an easy [decision]: it’s her that I have to be concerned about, not me. My body doesn’t belong to me during these nine months.

Cass’ account highlights the ways in which sublimating her own needs was difficult in practice (“I was dying to have [a Coke] some days”) but, nevertheless, an “easy” decision. Ideologically speaking, there was no question in her mind that her child’s needs were more important than her own desires, and this gave her the resolve to resist temptation. Her description of her prenatal

routine also contains a number of interesting contradictions: self-care was both a “no-brainer” and a decision she made, requiring intense willpower and self-control (avoiding the sodas she craved) but also made possible by a surrender of bodily autonomy, as indicated by her conclusion: “My body doesn’t belong to me during these nine months.” Cass’ statement also functions to draw a symbolic boundary¹¹ between herself and less responsible Others: unlike “a lot of women,” she continued taking her prenatal vitamin “religiously” even after the first trimester of her pregnancy.

A similar comparison was made by upwardly mobile, middle-class graduate student Juana (a California Latina), who told me, “I heard that some women are in some ways resistant, or are kind of angry...at their unborn child that they’re having to do this [change their habits during pregnancy]. But I never felt that way. If anything, I felt like this was excellent motivation for me to eat healthier. I’m a pretty healthy eater, but ... it helped me even more.” In this way, Juana described her prenatal cultivation of her child’s health as being aligned with her own longstanding self-care habits (a particularly middle-class narrative, as shown in the discussion of middle-class self-identity construction practices in Chapter Three). Like Cass, she also contrasted her point of view with “some women” who resented having to adopt new health practices. In further contrast to those unnamed Other women, White, middle-class California mother Bree described her self-education about health habits during her first pregnancy as a joyful experience:

You read everything...everyone’s opinion, and all these requirements you need...It was fun to think about! It was my first time. I wanted to know everything that was going on. How could I make myself feel better, or how can I make the baby healthier. And so there was a lot of excitement around that.

Bree’s statement echoes the optimistic claim made by journalist Annie Murphy Paul, cited earlier, that new research on the fetal origins of human health and behavior is marked less by fear of potential harm than by “the excitement of discovery.” Indeed, for expectant mothers with the time and resources to fully investigate their options, it may be that the emerging fetal origins research provides a feeling of empowered choice and the ability to influence children’s future outcomes. Certainly, at no other point in her child’s life will a mother have such complete control over the child’s body.

As Juana’s earlier point makes clear, though, not everyone can (or will) “read everything” or have “a lot of excitement” about learning to cultivate their baby prenatally. Poor and working-class mothers in my study tended to be younger than middle-class mothers with children of comparable age, less educated, and more likely to have had pregnancy come as a surprise. For many of these women, youth and unplanned pregnancy meant, at minimum, having a good deal less time in which to deliberate over and implement lifestyle changes. Given those constraints, they followed doctors’ advice dutifully, if not always with the exuberant pursuit of expertise that middle-class mothers like Bree described. Several poor and working-class mothers in my study

¹¹ Michèle Lamont (1992) defines symbolic boundaries as “the types of lines that individuals draw when they categorize people” (p. 1). According to Lamont, the drawing of these lines—*boundary work*—is a more or less universal human activity, although the criteria according to which such boundaries are drawn vary by class and social context. While people from all classes engage in boundary work, Lamont highlights the ways in which symbolic boundaries reinforce social inequality: “[T]hey are an essential medium through which individuals acquire status, monopolize resources, ward off threats, or legitimate their social advantages, often in reference to their superior lifestyle, habits, character, or competences” (p. 12).

spoke about changes they made that were difficult, but recommended by their doctors as critical for having healthy newborns. White, lower-class Florida mother Vanessa said, “the doctor told us that caffeine could make Timmy be born with addiction to it, and that it was bad for him, so I knew I had to [quit drinking Coke]. It was hard, because I don’t drink anything but that.” Trisha, a White lower-class mother from Florida, also made changes that were motivated less by excitement than by dread about possible harms to her unborn child. A longtime smoker, she worked hard to give up the habit once she found out she was pregnant, reasoning, “I feel like I’m killing my child, so I’m going to quit.” Similarly, White, lower-class mother Roberta’s pregnancy had given her the motivation to enter a methadone clinic to combat her heroin addiction. Many of these lifestyle adjustments reflect the class circumstances of lower-class women’s lives; poor and working-class people are more likely to smoke, use illegal drugs, and abuse alcohol (Boardman et al. 2001; Florida 2009; Layte and Whelan 2006). Furthermore, the types of lifestyle changes typically described to me by poor and working-class respondents were more often made in response to medical, rather than biomedical, recommendations. To the extent that respondents mentioned broader lifestyle changes, these tended to be made on doctors’ and nutritionists’ recommendations and to stress fairly basic guidelines for balanced nutrition dietary changes, such as those May described.

In contrast, women with middle-class backgrounds and cultural capital were more likely to have adopted wide-ranging biomedical lifestyle modifications with an eye to specific developmental advantages for their children, even as they continued to describe those habits as being aligned with their already-existing health ideology and practices. Juana, for example, asserted that her practice of exercising while pregnant could raise the baby’s IQ, and White, middle-class California mother Stephanie spoke about the importance of nutritional supplements like Omega-3 fatty acids for brain development. Dani, a White Florida mother who had a mixed class background (she received WIC aid and, along with her mother, subsisted mainly on child support payments from her professional, upper-middle-class father, with whom she had lived during some parts of her childhood), was quite well-versed in the links between prenatal care and child outcomes:

[Fish oil is] supposed to be good for brain development, like the nerve that connects the eye to the brain, things like that. I just...took a lot of vitamins. Basically everything that I did, I modified to help [my daughter], too. It was just ‘cause I wanted her to come out perfect.

As Dani’s account illustrates, her reasons for adopting some practices were specific (taking fish oil supplements to support brain development in general, and, in particular, optic nerve function). More broadly, though, she added, “Basically everything that I did, I modified to help [my daughter].”

The latter sentiment was common among many mothers in my study, especially those who were middle-class. Wolf (2011) names this all-encompassing devotion “total motherhood,” which “requires mothers to be experts in everything their children might encounter, to become lay pediatricians, psychologists, consumer products safety inspectors, toxicologists, and educators...Total motherhood is a moral code in which mothers are exhorted to optimize every aspect of children’s lives, beginning with the womb” (p. xv). Although total motherhood is premised on becoming a lay expert, it did not follow that every “total” mother in my study based her actions strictly on concrete, calculable goals. Instead, many women adopted or intensified

health practices on the rationale that it couldn't hurt their child, and might provide some theoretical health benefit. As White, middle-class California mother Lee explained, "I felt like it was a way to give [my daughter] the best possible odds that I could, by making sure that when I was pregnant I was eating lots of fruits and vegetables and nutrients." Florida mother Emily, also White and middle-class, became convinced that organic products would be healthier for her baby, with the result that "I switched my shampoos and lotions and stuff to organic, and I tried to eat more organic fruits and vegetables." And, like Emily, Cass worried not only about her foods, but also her personal hygiene and cosmetic routines; she stopped coloring her hair and transitioned to dye- and fragrance-free lotions. White California mother Misty perhaps stated the middle-class attitude most clearly, combining both specific health pursuits and a generalized effort to be healthier in all aspects of one's daily life. She cited a number of recommendations she attempted to follow ("Take folic acid when you're trying to get pregnant.' 'When you're breastfeeding, take extra DHA because it will help with brain development.'"), but then added, "I don't know about all of the science of it. But it can't hurt, so why not?" Other middle-class mothers expressed a similarly vague conviction about the rightness of their practices. Bree explained wanting to "make sure I was doing everything I was supposed to do as a mom to make sure [my daughter] had the best nutrients"—a noble, if seemingly impossible task—and Lee described her efforts to lose weight before conceiving a child thus: "If you're really heavy when you're pregnant then there are consequences for the baby...I didn't know all the details at that time. I just *knew* that my body was going to be able to handle being pregnant much better if I was not carrying all that extra weight." Thus, it would seem that middle-class motherhood requires women to sacrifice and manage their bodies not only in pursuit of real or even marginally indicated benefits, but also on the off chance that a general orientation toward healthier living might produce additional advantages for their children. From these women's descriptions of their body projects there emerges an overarching picture of a middle-class maternal *lifestyle*, marked by a range of self-improvement projects and a firm belief in the links between maternal health and that of the child. This middle-class notion of prenatal maternal lifestyle optimization contrasts with the approaches taken by many poor and working-class mothers. As described above and in the previous chapter, lower-class women do make changes to their prenatal health habits, but frame those changes as more modest in scope: with limited resources, they act with flexible agency and adopt what health practices they can. Those practices tend to be geared toward specific ends (such as avoiding fetal drug addiction) and may be restricted to the time period in which they are thought to yield the greatest reward.

Breastfeeding and Body Cultivation: The "Fourth Trimester" and Beyond

Body care expectations for all mothers carry over from the prenatal period into the weeks and months following childbirth. A number of middle-class mothers in my study referred to a popular term for the first three months postpartum—the "fourth trimester"—indicating the degree to which babies' bodily needs and development were still heavily tied to mothers' own health and bodies (primarily through breastfeeding). Postpartum, all mothers faced the choice of whether to attempt breastfeeding or to rely on commercial infant formula for infant nutrition. And while national statistics show that middle-class mothers are much more likely to breastfeed than poor and working-class mothers—a pattern that held true in my sample—women across classes shared a surprisingly unified belief in the superiority of breastfeeding.

When I asked women how they came to prioritize breastfeeding, they cited a range of different sources of advice and authority on the matter. White, lower-middle-class Florida

mother Frankie described her conversion to a belief in breastfeeding thus: “Once the doctor explained it to me and my mom pounded it into my head, I was just set on it.” Kiara, a Black, lower-class Florida mother, also credited health authorities with her decision to breastfeed, saying, “My Family Start provider [is] the one that...put it in my mind that it’s good for the baby, make the baby smart, and have his brain develop more.” Even India, a lower-class Black mother from California who fed her daughter primarily formula after experiencing breastfeeding difficulties, explained how persuasive the pro-breastfeeding message had been from her family, her community, and her doctor, saying, “My *whole* pregnancy, that’s all everybody talked about...Everybody had a lot of good things to say about breastfeeding.”

Misty, a White, middle-class California mother, acknowledged the influence of prenatal classes on her decision to breastfeed, saying, “I think that in a lot of the classes we took, the importance of breastfeeding was stressed, to where I felt like it was really important. People were telling me it was really important.” She added, “From what I read, I agree with that.” With this last sentence, Misty asserted her middle-class value of self-initiated research. Although she sought out the counsel of health professionals in her childbirth class, she then did her own independent research to verify what she had heard.

While the advice mothers received was essentially unanimous about the superiority of breastfeeding over formula feeding, the reasons for that preference were not always clear, a point that Nadia (a White, middle-class California mother) made when she stated, “I’m not one of those people who knows exactly what’s in the milk, I just know that it’s supposed to be beneficial, so I’m happy that I can do that.” This lack of clarity reflects not so much on Nadia’s ignorance as on the rather ambiguous scientific evidence that breastfed babies fare better than formula-fed babies in developed countries (Wolf 2011). Yet, even when they were unsure of the reasons, and even when they were unable (or unwilling) to breastfeed exclusively, nearly all mothers in my study—of all classes—had picked up on the message that “breast is best.”

Just as Joan Wolf (2011) finds to be true for pro-breastfeeding campaigns, many mothers explained their belief in breastfeeding by reference to both science and nature. Wolf writes, “In natural mothering advice...the virtues of nature are filtered by science and expertise...[this] is less a rejection than a selective embrace of scientific authority” (p. 83). While Wolf’s study could only speak to the breastfeeding campaigns’ framing, my interviews show that this frame resonates with women from a wide range of classes. Fiona, a White, middle-class California woman, told me, “Nature’s intended for you to be able to nurse this child.” Dani added, “It’s the best thing for your baby...It’s tailored exactly for your baby.” Here, Dani’s choice of the word “tailored” indicates both the fitness of breast milk for infant nutrition needs and, more vaguely, the belief that nature is the architect of that fit. Trisha used similar language, saying, “[With breast milk], your baby’s going to get everything that you need, because that was your design. That’s what you were designed to do, was to feed your child.” In making this statement, Trisha extended the notion of intelligent natural design to include not only breast milk but also women’s bodies more generally.

If beliefs about the conscious natural design of breast milk sounded vaguely religious, so, too, did many women’s references to the supposedly scientific benefits of breast milk. Lee obliquely referenced scientific research when explaining her decision to breastfeed, saying,

In my heart, I honestly believe that breast milk is better for brain development ... I’m the first person ever to graduate college [in my family]. My husband is the first person from his family to graduate college, and between us we have five

degrees, so [education] is *very* important to us. And I *know* that breast milk—and I think studies back this up—leads to better brain development.

For Lee, whose upward mobility—and her husband’s—had been hard-won, ensuring her child’s ability to succeed in school was of the utmost importance. Breast milk, she believed—and then revised her statement to claim that she *knew*—was the key to that success. Middle-class mothers Amy and Lara, both from California, also emphasized the connections between breastfeeding and IQ when explaining why they chose to nurse their children. WIC counselors touted these same perks to their clients, and some also mentioned additional health uses of breast milk, such as for the topical treatment of conjunctivitis, eczema, and diaper rash. With such rhetoric, it is small wonder that breast milk is sometimes referred to as “white gold” or “liquid gold”—its purported power to raise a child’s intelligence and cure infection sounds practically magical.

Given mothers’ near-universal belief in the superiority of breast milk, it might seem that they would feel similarly about not being able to provide that to their children. However, such was not the case; mothers’ reactions to breastfeeding difficulties differed significantly by class. Paz, a poor Latina mother in California, wished that she could have breastfed her youngest babies (twins with a health condition that necessitated a special infant formula), but she did not link this regret to a sense of failure. Likewise, White, working-class Florida mother Sarah expressed regret, but tempered that emotion with skepticism about the purported benefits her son might have received:

I always wanted to [breastfeed] because they say it builds their immune system up, and I wish I would have did it, because ever since [my son was] born, it’s been one thing and another with sickness... like ear infections. But I don’t really know how true it is. Because my brother was breastfed, and from the time he was six weeks old until he was four years old he was in the doctor’s office a lot.

These types of regrets, which were uttered with the verbal equivalent of a shrug of the shoulders, stand in stark contrast to the agonizing narratives I heard from middle-class mothers, many of whom equated breastfeeding failure to failure as a mother. Suzanne, a White, middle-class California mother, recounted her struggles to breastfeed, saying, “I had a lot of really personal stuff come up when I thought my milk [supply] was going down because I wasn’t eating enough, and I felt really hard on myself, horrible about my ability to have my body succeed in feeding my baby.” Likewise, Lara had to stop breastfeeding because of a then-undiagnosed problem her infant daughter was having with reflux. Reflecting back on that time, she lamented, “The what-ifs kill me sometimes. What if we had known? What if we had treated her?...I actually went back to therapy for the first time in years over this, because it was so devastating to me not to be able to nurse her.” And White, upwardly mobile middle-class Florida mother Louise, whose children could not breastfeed because of milk protein allergies, told me, “I was really disappointed about that...[I thought] ‘Oh, I’m a failure.’”

On one hand, much of the divergence in classed responses to breastfeeding failures can be explained by the different modes of agency these mothers adopt, a point elaborated in the previous chapter. On the other hand, these responses reveal mothers’ differing understandings of what it meant to care for themselves and their children. Middle-class mothers, as has been discussed above, tend to approach this project as a question of lifestyle—literally, cultivating a

particular and holistic style of healthy living. For such women, breastfeeding and its associated day-to-day rhythms formed an important cornerstone of that lifestyle; the loss of that cornerstone was, then, especially upsetting. In contrast, poor and working-class women valued breastfeeding for its practical benefits to health without making it part of some elusive lifestyle quest. They also weighed breastfeeding against other, more immediate ways of guarding their children's health. If breastfeeding could potentially protect against asthma, ear infections, and indigestion, it was still powerless to protect children from crime and violence. A significant minority of women in my study—all of them poor or working-class or, in one case, middle-class but from a poor family background—volunteered that they had direct experiences with sexual violence, domestic abuse, and/or living in unsafe neighborhoods. Shontel, a Black, lower-class mother living in California, described wanting to get her 4-year-old son involved in sports in a few years because it would keep him out of trouble: off the streets and not using drugs. Paz defied her WIC counselor's advice not to give her son a pacifier because he was struggling with emotional problems following their escape from a domestic violence situation. And Louise, who endured childhood rape at the hands of several older boys in her poor, rural hometown, proudly told me about her efforts to protect her own daughters:

Now that I have daughters of my own, they're not out of my sight. They're not out of my husband's sight. We are always with them. When they are on the playground, we're right there, like five feet away. We don't talk to other moms or anything. We're focused on them, because I don't want what happened to me to happen to them. And I know from my experience how easy that is to happen.

While physical and sexual abuse can affect children of any class, they are more prevalent in low-income communities (US General Accounting Office 1992; Wood 2003); poor communities also suffer from the harms of concentrated poverty, including neighborhood crime, drugs, violence, and inadequate housing (Knitzer 2000; Wood 2003). Thus, it is unsurprising that women from poor and working-class backgrounds were the ones most likely to stress the need to protect their children from physical danger. For these (and several other) mothers in my study, protecting their children from immediate, demonstrable harm was a more practical and worthwhile use of their energies than rigidly pursuing exclusive breastfeeding and mentally berating themselves when they failed.

Thus, in both pregnancy and the early postpartum period, women tended to gravitate toward one of two main approaches to cultivating their children's health and bodies. Poor and working-class women took the project of caring for their children's growing bodies and minds very seriously; with finite personal and financial resources, they tended to prioritize those practices that would yield the greatest benefit to their children, at the time they felt such changes would do the most good. Middle-class mothers, on the other hand, were more likely to spare no expense or physical hardship in the pursuit "perfect" parenting. Although they, like lower-class mothers, referenced particular benefits to children (most notably, practices that might boost intelligence and brain development), they also pursued a vaguer notion: the healthy lifestyle. Marked by a questing discipline that kept them searching for the next new thing, middle-class women adhered to the biomedical approach of not only avoiding harm but also optimizing one's life quality and chances through the cultivation and care of the body. Child health is a major goal of all these practices, but it is an elusive one. In a risk society, "no one is truly healthy, and healthy behavior is rewarded not with an absence of sickness but with an ineradicable 'semi-

pathological pre-illness at-risk state” (Wolf 2011: 63). Given the fleeting, always-just-out-of-reach quality of health, perhaps a more immediate reward kept these mothers striving: not only health, but status.

Infancy, Toddlerhood, and the Transmission of Health-Cultivating Values

By their nature, pregnancy and breastfeeding involve acting upon a child’s body (often by way of the maternal body) in order to promote health in both the present and the future. Toward the end of infancy, however, parents’ considerations about how best to cultivate their children’s bodies and health became increasingly complicated. As children’s developmental needs expanded beyond eating and sleeping, the number of choices parents faced multiplied as well. Mothers across classes worried about teaching their children to care for and respect their bodies, often in contrast to the dissatisfaction or embarrassment they recalled feeling about their own bodies as youth. They debated the social and physiological benefits of participating in sports, worked to instill habits of good manners and bodily hygiene, and taught their children about “good” and “bad” foods by example. In all of these realms and beyond, we can observe class cultural differences and, thus, consider the ways in which parents transmit not only physical health, but also embodied cultural capital to guide children’s care of their own bodies in the years to come.

Sacred, Free, and Happy: The Ethics of Cultivating the Body

When I asked women what they hoped their children would come to learn or practice with regard to their bodies and health in the future, nearly all mothers gave an answer similar to that of Charlotte, a biracial middle-class woman from California: “I would like [my daughter] to feel really comfortable with her own body, and to love it.” This notion of loving or respecting one’s own body was often described as treating one’s body as *sacred*. White, middle-class Florida mother Diane explained the lesson she hoped her children would learn, saying, “This is the only body you get in your whole life and you need to take care of it.” For Diane, that meant learning to think about the consequences of one’s actions, whether eating unhealthy foods or getting a tattoo. Joan, a middle-class White mother living in Florida, agreed with this sentiment, adding that it was important to think of the body as a “temple.” By defining the body as a sacred space, these mothers hoped to help their children avoid harmful, polluting substances like drugs and junk food while honoring their bodies with exercise and healthy living. Yet, even as words like “temple” and “sacred” infused middle-class mothers’ discussions of the body, it was lower-income women who tended to tie these practices explicitly to religion. Gita, a temporarily lower-class Indian American woman in California who belonged to a religious group with relatively strict behavioral guidelines, explained her dietary choices for herself and her children. She told me, “There’s a lot of doctrinal principles, especially about the things we put into our bodies, and not putting harmful substances [like] drugs, alcohol, and tobacco [into our bodies].” Black, lower-class India’s religious affiliation was nondenominational—she identified simply as “Christian”—but it, too, guided her efforts at teaching her child the correct body-care values. She said, “I want [my daughter] to respect her body. I want her to cherish it. I want her to feel like it’s a gift from God and that she has to put the right things in it.” The different vocabularies used by middle- and lower-class mothers to talk about bodily sacredness likely reflect their differing average levels of religiosity—middle-class mothers in my study were less likely to identify as belonging to a religious group, particularly in California. However, with or without the language

of religious strictures, many mothers across classes found images of purity and defilement useful for instilling an ethic of self-care in their daughters and sons.

Another ethic that informed many mothers' childrearing practices, particularly those of middle-class mothers of daughters, was feminism. Sometimes women explicitly claimed these sentiments as feminist, while, at other times, they did so implicitly by describing concerns about gender inequalities. Suzanne, for example, worried about the effects of "princess" culture, the male gaze, and the fact that cosmetics were being marketed to girls not much older than her daughter. When I asked her what she did want for her daughter, she responded, "I want her to feel free and happy, and comfortable in her body, and just be innocent. Just be able to eat what she wants to, to be proud of her body moving outdoors, and feel it being fast and strong and athletic." Suzanne and many other mothers described to me their own struggles with being comfortable in their bodies—and their experiences of being judged as flawed—while hoping that they could protect their daughters from going through the same difficulties. Cass explained, "There's so much pressure on women [to be thin], in particular, that I hope I can shield [my daughter] from some of that." White, lower-middle-class Florida mother Hillary added, "Whether she's 200 pounds or 140, I want her to be happy with how she looks. I don't want to give her crap about it." Hillary's comment about not wanting to give her daughter "crap" for looking a certain way hinted at how she and other middle-class women in my study wished to distance themselves from their own mothers and from other family members, many of whom had pressured them to conform to slender body norms. In taking this approach, Hillary hoped to help her daughter accept any perceived "flaws" in her body and to develop a positive sense of self. Thinking about a different type of family legacy, Florida mother Louise and White, middle-class California mother Lara both spoke of the likelihood that their daughters would inherit body shapes similar to their own; Louise hoped that her children would "exercise, be health conscious, but in my family they're going to have a big butt...Mine is, my mom's is, my grandma's is...It's just gonna be. Just accept that, because you can't really do anything about that." Thus, whatever other aspirations mothers had for their children's body cultivation and class futures, nearly all wished for their children to be happy and healthy in their bodies above all else.

Practical Matters: The Social, Intellectual, and Physical Benefits of Body Cultivation

At the same time, mothers also recognized bodily cultivation as a key to unlocking children's developmental potential. As such, their strategies for instilling self-care values were highly practical, focused on not only beliefs about the body but also intellectual and developmental outcomes. One example of where these two orientations to body care overlap is in mothers' ideas about exercise. As Suzanne noted above, part of her hope for her daughter was that she would grow to love her body, in part, by being strong and active. White, middle-class California mother Greta agreed, saying, "I want to put [my daughter] in gymnastics, and get her used to using her body, keeping it fit and strong." Several middle-class mothers explained to me that they understood the value of exercise—having become physically active as adults—but hoped to instill this value at an earlier age in their own children.

The benefits to such early physical activity, mothers asserted, were wide-ranging. Similar to Juana's contention that exercise during pregnancy could lead to positive developmental outcomes for her children later in life, White, middle-class California mother Kirsten noted both the physical and nonphysical benefits of sports, saying, "I think sports are really good for a person to develop intellectually...It helps you develop, and gives you something that I think other academics can't, that [can] help you in academics and other parts of life." Lower-class

mother Paz concurred, saying of her 11-year-old's wide range of activities, "It's good for many things. It's good for the body, good for her to know more people, [to] have more friends."

Beyond athletics, mothers of different class backgrounds adopted different embodied strategies to help their children learn appropriate self-presentation. A handful of lower-class mothers emphasized hygiene to their children. Ji-Eun described her efforts to get her children to brush their teeth, and May spoke at length about getting her children to shower correctly, saying, "I make sure I watch them when they're taking a shower, especially my daughter. She likes to...wash real quick. [I tell her] 'Go in there and take your time, girl!'" Cleanliness is one way of presenting oneself as socially competent, and, for those living in poverty, it may be particularly important to avoid being stereotyped as dirty, abject, or as a bad parent (for failing to keep children clean) (Pascoe 2007; Steedman 1987).

For middle-class mothers, on the other hand, a common concern about building social competence was that their children learn proper manners at the table and around other adults. Amy and several of the other parents in her well-to-do California neighborhood had organized themselves into a semi-formal parenting group, and she proudly told me about the group's decision to teach their children how to address an adult politely as, for example, Mr. or Mrs. Jones (rather than using first names). She admitted that this was a little bit old-fashioned but felt it was important for children to practice their manners around adults. In this way, Amy and her peers modeled the middle-class parenting approach that Lareau (2003) labels "concerted cultivation," in which children spend significant amounts of time with adults—often more than they spend with other children—and learn the social conventions for conversing with adult authority figures.

One place that many middle-class mothers in my study reinforced these social conventions was at the dinner table. Lara explained, "I think it's what everyone wants their family dinner to be like, just some kind of checking in with each other and being a family...It's great to try new foods and have the food be yummy and healthy, but I think more of the social part [when I organize family meals]." During these meals, Lara strove to develop her children's conversational skills, teaching them to ask everyone at the table about their day. Misty added that she thought family meals could improve her children's dietary awareness, comparing them to people who "have poor eating habits because of convenience—the quickest isn't always the healthiest." And Nadia, who struggled to have a few family meals every week despite her husband's demanding work schedule, emphasized the potential intellectual benefits of this practice: "I know that family dinners around the table are supposed to enhance children's academic performance, according to a study that I read...In general, I think it's a good tradition." Indeed, several middle-class mothers like Nadia mentioned the importance of striving for family meals even in the face of scheduling difficulties, and Lara contrasted the most "convenient" or "quickest" meals with what she felt was best.

For the lower-class mothers in my study, work and school commitments—and the fact that the majority were single parents—almost always placed this goal out of reach. India was one of the few WIC-eligible mothers in my study who mentioned sit-down meals as a priority for her daughter. She told me, "I think it's always better for a parent and a child, or a parent and their children, to sit together and eat for dinner. I think you're going to eat all your food, and you're going to sit there and have a conversation." A single parent, India's vision of a family meal included only her and her daughter, and she noted that even this was a departure from what she had grown up with, saying, "When we grew up, we used to sit *anywhere* in our room, and then five minutes [later] you're coming back and you're hungry!" For many other low-income

women, that on-the-run approach to eating was the norm; Paz described to me how, between changing diapers and ferrying her older children to school, her own meals usually consisted of coffee and granola bars—sometimes a handful of almonds or a glass of juice if she was eating “good foods.” While she did her best to make sure her older children had social experiences outside the home, a sit-down family meal around the dinner table, with all of its potential academic and social benefits, was simply not in the cards.

Learning to Eat: Good Food, Bad Food, and the Class Politics of Consumption

Although self-respect, exercise, hygiene, and manners were important lessons the mothers in my study strove to teach their children, their strongest—and most class-differentiated—opinions tended to concern the “right” foods to eat, and the “right” ways of eating them. By the time children began consuming solid foods around six months of age, mothers were already veterans of the ongoing debates about breast milk and formula. Yet, the introduction of solid foods was marked by a new round of value-laden decisions: Are organic products worth the extra cost? How can parents confront children’s picky tastes in food? Should children be allowed “junk food” and, if so, under what circumstances? For mothers enrolled in WIC, nutrition staff established relatively clear and consistent guidelines that, while not always possible for mothers to follow, provided at least a roadmap to guide their efforts. Middle-class mothers, on the other hand, confronted a host of food and eating ideologies through their self-directed research. As in their decisions about how to care for their own health, they navigated their sometimes-conflicting findings by tying children’s consumption to their own self-identities and to those they imagined for their children in the future. Ultimately, as with breastfeeding, the foods that middle-class women identified as unambiguously “good” tended to be those requiring a substantial investment of time, money, and/or knowledge: foods that were relatively unattainable for lower-class families.

As mentioned in Chapter Two, nutrition counselors at WIC spent a majority of their time in group classes and individual counseling sessions talking about healthy foods. Most counselors lined the walls of their offices with pictures of beautifully photographed, colorful vegetables and with diagrams showing the sugar content of various beverages (with a corresponding number of sugar packets stapled below each picture). Other common visual aids included child-sized cups to illustrate correct portion sizes for toddlers and young children, and handouts depicting the new “My Plate” method of creating a balanced meal (which, by 2011, had replaced the Food Pyramid as the U.S. Food and Drug Administration’s official nutritional teaching tool). For mothers in WIC, both these guides and individual suggestions from their counselors helped them confront picky appetites in children. White, lower-class Florida mother Nicki, for example, turned to her nutritionist for assistance in overcoming her son’s pickiness about vegetables and meat, and with “get[ting] the kids interested in nutrition.” Paz appreciated the advice she received from her nutritionist—a mother herself—about creative strategies for encouraging her children to eat vegetables. She recalled one such conversation to me, saying, “She says, ‘[There are] many different ways...like vegetable juice.’ And the kids like it like that. Or she said, ‘Make it like decoration and make a face [out of cut vegetables] for the kids,’ and they like that and want to eat it.” In this way, WIC staff reinforced the nutritional guidelines of the program by talking to clients about how to make the recommended behaviors work for them, to which many poor and working-class mothers responded positively.

Alongside their comments about so-called “good” foods—fruits and vegetables—low-income mothers also spoke at length about the types of “bad” foods they tried to avoid. For

example, Sarah noted, with pride, her son's seemingly natural inclination toward being a "good eater." She told me, "He eats fried foods sometimes, but he's a really good eater. He's not into sweets and junk...He loves his vegetables. He'll sit there and eat vegetables all day long." Like Sarah, other lower-class mothers tended to describe "bad" or "junk" food as being sweet or greasy; many contrasted their own ingrained eating habits with what they sought to instill in their children. Shontel commented, when I asked her what she would purchase if WIC coupons were less restrictive, "I'd probably buy junk food, like chicken, macaroni, fries, burgers...I like things like that, but I try also to get him nutritious things, but it's hard because I don't really eat it myself. I want to set a good example, but it's kind of hard. I don't like it either."

Many of the poor and working-class mothers I spoke to attributed their difficulties in feeding their children healthily to their families, both indirectly (as when India explained, "I'm a sweets eater. It's just the way I grew up") or directly. In the latter case, several mothers struggled to model good eating behaviors but ran up against family members who did not share their food values. Trisha, for example, appreciated her mother's home cooking while she was growing up, but now worked to adapt family recipes for foods like meatloaf to be less fatty. At the time of our interview, she was anxious about the influence of other relatives who took less care with their diets: "I don't want [my children] to be obese. I have a little cousin who's now 12, I think. The poor thing, her parents don't care what she eats. She eats Little Debbie cakes all day long. And I don't want my kids seeing that. So we don't really go to their house that often." Trisha's distaste for her cousin's eating habits led her to erect both a symbolic boundary (between her own good parenting and her aunt and uncle's more indifferent style) and an actual one, limiting her daughter's contact with that branch of the family. For White, Florida WIC mother Christine, who labored to manage her son's diabetes through diet, the challenge was family members who directly undermined her hard work. In a voice strained with exasperation, she confided to me, "My mother-in-law visits us very regularly—like multiple times a month—and every time she comes over she brings...all sorts of stuff. She's a Type 2 diabetic as well. I'll get up and she'll have gotten up with [my son] Bobby. They'll have had doughnuts for breakfast." Christine sighed loudly, concluding, "This is not helping. I've told her if she wants to buy him a treat, buy him fruit! He loves fruit." Countless public health scholars have noted the prevalence of so-called "junk" foods in low-income communities, with explanations ranging from the recently-discounted "food desert" hypothesis about the unavailability of fresh foods in poor urban neighborhoods (Lee 2012) to explanations citing the cost-effectiveness of unhealthy "energy-dense" foods (Drewnowski 2009) to the notion that sweet, salty, and/or fatty "comfort" foods are an important source of short-term pleasure for people whose lives are particularly stressful (Dallman, Pecoraro, and la Fleur 2005). Whether or not any of these factors were in play, low-income women in my study often described the difficulty of teaching their children about WIC-approved healthy eating when they had little experience eating that way themselves.

Nevertheless, the majority of low-income women in my study shared similar beliefs about what constituted "good" and "bad" foods, and these understandings were reinforced at the WIC office. The challenges to feeding their children more "good" and fewer "bad" foods tended to involve financial barriers and an absence of family culture to support "good" eating habits.

Middle-class mothers, on the other hand, had a wider-ranging set of answers to my questions about the foods they preferred to feed their children. For these women, the axis of "good" vegetables-"bad" junk food was less important in their day-to-day meal choices than eating local produce, purchasing ethically sourced meats and dairy—organic when feasible—and preparing "whole" foods while avoiding prepackaged or "processed" products.

Charlotte was a strong advocate of what she and other mothers called “whole” foods—generally speaking, these were foods in their natural form (such as fruits, vegetables, and whole grains), cooked or raw, which had undergone a minimum of processing or treatment with preservatives. While she cited practical concerns about the effects of preservatives on children’s health, the language she used to do so was highly charged with moral and emotional sentiments. Laughing as she responded to my question about why she chose whole foods for her daughter, she said, “Processed foods are the devil’s work! They are just bad! They’re just not good for you.” Although Charlotte’s reference to these foods being “the devil’s work” was tongue-in-cheek, her strong ideological stance was, nevertheless, a common one among middle-class mothers on the subject of food. That stance also functioned, to some extent, as a symbolic boundary between classes. Christine, a well-educated but financially vulnerable mother in WIC, could not afford to write off processed foods as “the devil’s work” even though she knew that fresh foods were supposed to be healthier. She explained,

When we do have more money to spend on food, there’s a lot more fresh stuff... If there’s fresh fruit in the house, then I really feel like, “We’re doing alright now.” Because [it’s] expensive and immediately perishable, so you actually have to move through it kind of fast. So if it’s there, then you must be doing pretty good. That’s always the marker, fresh fruit.

While, as Christine pointed out, fresh food meant one thing (financial security) to her, it meant something very different to the solidly middle-class women I interviewed. In a similar ideological vein as Charlotte, Kirsten added that her food choices were about self-identity. She told me, “I want [my daughter] to see where the food comes from...I think that’s honest. I think it’s easy to forget what this [food] is and where it came from, and how you get it. So squishing some apples in the juicer and making juice every once in a while is super important. It is who we are from a philosophical standpoint.” Kirsten described taking her child to a farm to watch cows being milked, and she tied the food she fed her family to the lessons she hoped they would learn about it, saying, “It makes up who we are.” In comments like these, Kirsten and other middle-class mothers again demonstrated the links between self-identity and dietary or self-care practices discussed in Chapter Three; furthermore, they explicitly spoke of transmitting those same priorities to their children.

Yet, despite Kirsten’s breezy comment about tossing some apples in a juicer “every once in a while,” the commitment to serving whole foods was usually quite time-consuming for the middle-class mothers I interviewed. Hillary, who had only started to learn about whole foods after she became pregnant, noted how time-intensive this pursuit was, saying, “It’s very important to me to try to prepare whole foods...rather than prepackaged foods. I like to control the ingredients that I put into things. I spend a lot of time reading recipes and looking for different ideas.” For Hillary, and for many other middle-class mothers, the measure of rigid agency and control associated with this way of eating made it worth the significant effort it required. Diane, who told me how proud she was to have developed a recipe for homemade black bean brownies “instead of opening up a package of Oreos and tossing those at [the children],” nevertheless fretted that she lacked the time to feed her children whole foods exclusively. With another baby on the way, she sighed, “I don’t know when that’s realistically going to happen.” For many of these mothers, the appeal of whole foods was that they allowed mothers to exercise greater control over what was going into their children’s bodies (a sentiment,

moreover, that informed many women's advocacy of breastfeeding). At the same time, just as with breastfeeding, this particular mode of care-through-feeding placed enormous demands on mothers' time and energy. The very convenience and shelf life of packaged foods that appealed to poor, single mothers on a budget, generally made possible by artificial preservatives, became a point of ethical concern for middle-class mothers. In this way, the eating habits and values that middle-class mothers held up as ideal, both as good mothers and to raise health-conscious children, were rarely to be found in lower-class households.

Another area in which these distinctions showed up was in many middle-class mothers' preference for local, sustainable, and so-called ethical meats and produce. In both California and Florida, families were fortunate to have access to diverse, year-round local produce through farmers' markets and farm shares (paid subscriptions to receive a selection of locally grown foods throughout the year). So common were these options that the WIC and SNAP (food stamp) programs in these states had begun experimenting with special vouchers to encourage low-income families to shop at farmers' markets. At the time of my interviews, however, none of the WIC-eligible mothers I spoke to had taken advantage of these special programs, if they had even heard of them. By contrast, middle-class mothers spoke at length about the importance of locally sourced foods. Charlotte explained to me, "I think [about] the politics of eating seasonally and sustainably...so the food won't be traveling long distances. I always end up supporting local farmers. And I really want to my daughter to know that and learn that through eating too." To Charlotte, her eating choices represented an ideology that she hoped to pass on to her daughter, simultaneously nurturing her health and her political consciousness. Diane added, "I get chickens that are free range, pasture raised. That's one of the things that is important to me when I'm choosing food and meat. I used to be vegetarian, so that's kind of my compromise." Diane's "compromise" was a familiar one among middle-class women, many of whom had experimented with vegetarianism, veganism, or other restricted diets before becoming pregnant. Now wrestling with the demands of feeding young children, they sought to balance their ideas about healthy eating with their children's appetites and nutritional needs. Joan, for example, spoke guiltily about her own compromise for getting her son to eat protein, saying, "It's not an organic, pastured turkey breast [that I give him], it's just Ovengold turkey breast. It makes me feel—not that I'm failing, at least he's getting protein—but it's still not the optimal protein." Joan had, of late, become an adherent of what she called "primal" eating, which emphasized whole foods like plain meats, nuts, and vegetables while eschewing grains and processed foods. For her, acculturating her son to eating lean proteins ultimately trumped her misgivings about supporting a large food corporation.

As many of these stories indicate, middle-class mothers' efforts at transmitting particular lessons about ethical food emphasize both healthy eating and, critically, the process of becoming a knowledgeable consumer. Just as these mothers shopped around for the most healthy, personalized plan for self-care during pregnancy and postpartum—and, in the process, engaged in a project of not only self-care, but also self-identity creation—they aimed to instill the same critical consumerism in their children. Bree, who more or less explicitly tied her childrearing habits to status transmission by stating that "knowledge is power," continued, "I want [my children] to be confident, secure, and I want them to be curious. I want them to feel, if they want to ask questions, to know how to find answers. In terms of nutrition, I want them to understand why I'm asking them to eat vegetables, maybe why I steer them away from sugar." This aim of developing her children's curiosity, teaching them to ask the right questions, and empowering them to find the answers provides a clear early example of the "concerted cultivation" approach

to childrearing that Annette Lareau finds among middle-class parents of slightly older children. Michèle Lamont, too, notes the degree to which this inquisitiveness is valued among the middle classes, writing:

In contrast to working-class people, upper-middle class people consider it more important to transmit to their children a certain intellectual curiosity, a taste for discovery, and a need for self-fulfillment. (1992: 100)

This taste for discovery (and for a wide range of foods) was indeed prevalent among middle-class mothers in my study. Stephanie, for example, prided herself on the adventurous palates she had nurtured in her children, and she insisted that being an informed consumer was key to maintaining a coherent self-identity. She told me, “We have to instill certain things in our children, instill certain confidences and values so that...when they’re presented with everything that they’re going to be presented with, that it isn’t so overwhelming that they lose a sense of self.” Indeed, Stephanie’s children had already been presented with a wide array of foods and life experiences, because she and her husband enjoyed world travel and tended to bring their children with them; she beamed as she told me a story from one trip to Italy, saying, “[My daughter] blew away a couple of tourists that were four seats away from us: she ate a mound of pasta with clams and pesto!” Middle-class children like Stephanie’s were thus likely to face numerous options for consumption and self-identity, and learning to navigate those choices through selective purchasing became an important skill for competent middle-class adulthood.

Although Stephanie and her peers identified these skills as having *personal* importance for health and identity, a comparison between the foods valued by middle- and lower-class mothers, and the reasons they gave for choosing those foods, also reveals the extent to which knowledgeable consumption by middle-class parents and children is a *classed* project of maintaining cultural distinction via invisible symbolic boundaries. Nowhere was this pattern more evident than in the case of one category of foods: organics.

For many years, the word “organic” has been used as shorthand for both “healthy” and “elite.” Organic produce has long tended to cost more than conventional agriculture because of its avoidance of labor-saving artificial fertilizers and pesticides, and, at least initially, it was most likely to be found in high-end grocery chains like Whole Foods. In the past few years, however, organic produce has found a niche in mass markets. In 2006, superstore chain Wal-Mart announced that it would be expanding its grocery sections to include organic food, a move that drew criticism from long-time organics advocates as being cynical, motivated less by an interest in sustainable, local agriculture than by a desire to capture a share of the growing market in such products (sometimes called “greenwashing”) (Kummer, March 2010). As Wal-Mart and other lower-end grocery stores began offering organic produce, they pushed prices down and, in so doing, made a formerly high-class product available to a wider population.

At the time I conducted my research, many WIC-eligible and recently middle-class mothers mentioned organics as being the ideal—if still usually out-of-reach—food to feed their children. Lower-class Florida mother Ji-Eun said, “For my children I want to choose the organic, but financially [I can’t] every time!” Tina, a Black, lower-class California mother of one, felt so strongly about the benefits of organics that she criticized WIC for not providing them, saying, “You should be able to choose organic if you want. The [breads] that are whole grain—the better breads—are the ones that you can’t get. But you can buy this Wonder Bread stuff. You want to eat healthy and you can’t get this.” Hillary, a middle-class mother in Florida, had been briefly

eligible for WIC when she first had her baby but declined the benefits for this very reason. She told me, “[WIC] wasn’t as healthy as I thought it would be...It wasn’t much healthy food. But I’m not as poor as some people are. I’m like ‘Gosh! That just sucks for those people that that’s what they have to live on!’” When I pressed Hillary to explain further what she meant by healthy food, she replied, “I guess eating the most whole type foods, the least amount of chemicals. Organic if you can.” Thus, it would seem as though the mass marketization of organic foods in retailers such as Wal-Mart has not necessarily put them within financial reach of poor and working-class families. Culturally speaking, though, there has been a broad dispersal of the *ideal* of organic eating. I suggest that this shift has led to a devaluation of the “organic” ideology as a marker of status and distinction.

Among middle-class mothers in my study, organic products were mentioned casually, as part of a laundry list of considerations when deciding on the right foods to serve their children. Kirsten explained her criteria to me thus: “[My kids] eat a lot of dairy, a lot of cottage cheese, a lot of milk. So I still go organic with the cottage cheese, and milk, and eggs, because that’s what they eat. But the bread? No. Because the organic bread goes bad too quickly. And the produce? I care more that it’s grown locally.” Kirsten’s reasoning displays the kind of self-assured practicality and informed decision-making that middle-class mothers in the previous section described working to cultivate in their children. Indeed, as criticisms of Wal-Mart’s move into the organic food market show, an organic label may no longer be sufficient as a marker of either class or informed consumption. Kirsten described looking at labels on produce not only to see whether they were organic, but also to check on their origins; furthermore, she was able to distinguish between the potential benefits of organic bananas (where the part most likely to come into contact with pesticides, the skin, is not eaten) and those of organic strawberries (for which she ultimately decided that the health benefits of organic production were worth the additional cost). These same sorts of research and cost-benefit analysis were repeated by numerous middle-class mothers in my study; many pointed out that eating non-organic foods from small, local farms and businesses could be healthy, cost-effective, and morally righteous. Given this transition from valorizing expensive organic produce to preferring cheaper local, sustainable agriculture, it might seem that access to the “right” way of eating would become democratized. This, however, has not been the case. As lower-class consumers have gained cultural, if not financial, access to organic products—long the cultural province of middle- and upper-class shoppers—the latter have shifted their consumption preferences once again. Feeding one’s children the right foods, and teaching them to make the right choices for themselves, appears less a function of financial access than of informed consumerism via *cultural knowledge*. Just as upper-class subjects have, famously, shifted the goalposts for educational credentialing at the moment when access to higher education became widespread in the U.S. (Lucas 2001), so too have middle-class consumers reimagined their gold standard for self- and child bodily care in the early 21st century. Thus, middle-class mothers’ projects to teach their children about researching where their food comes from and how best to care for their own bodies are not only about personal health; they are also teaching children how to pursue health as a *lifestyle* and an ever-shifting quest for self-identity via body care, thereby reinscribing them as middle-class subjects. Ultimately, these efforts form a key pathway by which embodied status transmission occurs from one generation to the next.

Conclusion

As the findings of this project show, middle- and lower-class mothers alike strove to care for and cultivate their children's health, beginning in the womb and continuing into early childhood and beyond. Yet as children grew, differentiated class cultural patterns of childrearing and child health cultivation began to emerge.

Many of the women I interviewed were still relatively new to motherhood, as in the case of those who were pregnant with or breastfeeding their first child; thus, the hopes and dreams they articulated for their children's future body-care values were often speculative. Unsurprisingly, then, most women (of all classes) tended to refer to their own childhood and the bodily values and experiences they inherited from their parents when trying to outline what they would want for their children. For middle-class mothers, specific lessons about health from their own mothers were not always relevant (given significant changes in pediatrician recommendations for everything ranging from bottle-feeding to the question of whether babies should sleep on their backs or their stomachs). However, for those who came from middle-class homes themselves, the lesson that stuck with them was a keen eye for the latest research and childrearing trends and the drive to stay abreast of those trends, a cultural value they sought to pass on to their children as well.

Women from lower-class backgrounds, on the other hand, were more likely to talk about the unhealthy habits they had learned from their families, and many of them struggled to overcome their initial habituation to particular types of "unhealthy" foods and beverages. By introducing fruits and vegetables into their children's diets early, and by urging their children to be active, these mothers labored to imbue their children with an embodied set of tastes and habits that would become a part of their long-term habitus. In this way, they hoped to provide their children with particular embodied advantages that they, themselves, had missed out on in childhood. WIC counselors shared this hope, as, for example, when Florida counselor Traci stated, "Over time, if we can get the kids to drink one percent [milk] when they're two, then they're going to drink it when they're thirty."

On one hand, these efforts by low-income mothers and their WIC counselors demonstrate an understanding of the way that bodily tastes and habits can become second-nature if they are introduced early and reinforced through repetition—in short, if they can be incorporated into the habitus. On the other hand, the lessons about food and health that WIC endorsed were often simplistic, highlighting the importance of one "right" way of eating and giving short shrift to critical consumption skills in mothers and their children. In the long term, this approach seems likely to improve the health of low-income women and children, but it is unlikely to alter the function of bodily habits and knowledge as a site of class distinction.

Speaking of public education and hygiene programs for the poor in eighteenth-century Europe, Nikolas Rose (1990) writes, educational reformers believed:

Working-class families suffered, at best, from a kind of cultural lag whereby they were fated to play out the child-rearing nostrums of a past age, which progress had made redundant...At worst, the physical, intellectual, and emotional constraints upon the family lives of the working class seemed to be positively dangerous to the prospects for their children. (Rose 1990:184)

Similar dynamics would appear to be at work in the present day. WIC and other public assistance programs for low-income families seek to protect against the latter concern (that the material circumstances of poor families are "positively dangerous to the prospects for their children"), but

ultimately do little to address the former (in which working-class families are perpetually lagging behind, “fated to play out the child-rearing nostrums of a past age”). In this way, nutrition education for low-income mothers offers enough information to help them raise children who are more or less healthy and productive, but not so much that it threatens the embodied cultural distinction that middle-class mothers transmit to their own children.

CHAPTER SIX

Conclusion

At the beginning of this project, I suggested that the contemporary United States is what we might call a self-help society, not merely because of the commercial success of self-help books and talk shows, but because of political restructuring in the form of neoliberal social and economic policy. As individuals are increasingly exhorted to become profit-oriented, self-maximizing “enterprising subjects,” the overarching message has been that help, if it is to be had, must come from oneself. To be such a subject requires *control*: taking charge of one’s life circumstances and oneself, and manipulating them to achieve desired ends. In this ideological climate, the body takes on particular importance as a target and signifier of such control. Even if we have nothing else—even if we lack control over much in our lives—we can still exercise control over our bodies, or so the thinking goes. Failure to exert control over the body and to achieve normative standards for health and appearance thus signifies a *moral* failing.

For new and expectant mothers, not only are these standards not relaxed, but they may actually be heightened, demanding that women demonstrate control over their own needs and habits and the bodies of their children. Pregnancy, a time many women once looked forward to as a period in which societal expectations about slenderness and dieting would be relaxed—a period in which they could proudly “eat for two”—has morphed into a time of heightened scrutiny. Physicians warn mothers-to-be about the dangers of gaining too much weight during pregnancy, and, in many cases, urge women to lose weight before ever becoming pregnant. In this climate, “good” expectant mothers learn to become informed consumers about maternity care, researching different options for giving birth and, once their delivery date comes near, preparing a plan for the birth to ensure that their wishes are respected—that they will maintain some degree of control over the process. Following childbirth, these expectations multiply. The near-unanimous belief that “breast is best” is accompanied by a rhetoric telling mothers that only with breast milk can they be assured control over what their child is eating; alarming reports about harmful chemicals in infant formula and baby bottles add to this discourse. Meanwhile, popular magazines comment on celebrities’ “post-baby bodies” and note the speed with which these women are able to lose their “baby weight.” By making such bodily restoration a question of “when” rather than “if,” these popular cultural texts elide the possibility that pregnancy and childbirth might irreversibly alter a mother’s body, and they contribute to cultural norms stating that control over the body is within reach for all women, not only those whose job is to be slender and who can purchase the services of personal chefs and trainers to help them succeed in that pursuit.

In this project, then, I have sought to show how class cultural norms and material inequalities work together to produce divergent embodied experiences of motherhood for women across classes. These factors shape the types of self-care advice and support to which women are exposed during pregnancy and after, the community norms to which they are held accountable, and the means by which they seek to reach those norms in hopes of bridging the gap between “what [they] are and could become” (Rose 1990:11). In the case of mothers, moreover, this neoliberal tension is transformed into a question of what *mothers* are, and what their *children* could become.

Ultimately, the class politics of bodily self-care and child cultivation in the pre- and postpartum periods come down to two questions: resources and choice. For poor and working-

class mothers, class manifests itself primarily as a limitation to the types of foods, personal care routines, and even timing and style of motherhood they pursue. Good maternal embodiment is based not on deciding between multiple promising options for health, but on marshalling all of one's energy and resources to pursue one more or less shared, simple vision of health, one that tends to be reinforced (for women in my study) by lessons given at WIC. For middle-class mothers, class privilege creates a wealth of self-care options among which to choose. In the words of California mother Stephanie, the question is how to knowledgeably choose between those options while staying true to oneself. Decisions about exercise, prenatal care, nutrition, and childrearing become a means of pursuing not only health, but also self-identity projects that act as both personal quests (as women strive to construct coherent narrative arcs about their choices, agency, and personal values) and status contests (in which middle-class mothers seek to validate their choices by comparison to their own mothers, middle-class peers, and lower-class Others). The consequences of these decisions do not end with mothers' own status, but, rather, extend into the embodied knowledges and markers of distinction that they transmit to their children.

In one sense, this class dichotomy in the meanings and consequences in how mothers have raised their children is hardly new. Rose recounts,

For some two centuries, perhaps more, two distinct types of education have been designed for young children, one directed at the child of the well-to-do, the other at the child from the working class. The former has sought, by and large, to maximize the potential of the adult that the child will become, seeking to convince parents that a particular way of thinking about and acting upon the child in its infancy will help them promote their own lineage and secure the best future for their offspring. The latter has sought, in different ways, to minimize the threat to social well-being that the future adult might represent, by supplementing the work of the mother in various ways, and by training her in the correct ways of conducting her tasks. (1990: 178-9)

In another sense, though, the grounds on which classes are divided from one another have shifted in the neoliberal era. With regard to the body and its care, it is increasingly the case today that all subjects confront a more or less unified set of bodily norms. The body must be cared for, maximized, made productive and efficient, and taught to consume—in moderation, but, nevertheless, to consume—the products of a capitalist economy. The class dichotomy is maintained not through two sets of norms, as it once was, but by neoliberal morality and the differential *access* of classed subjects for embodying those norms. If access to normative embodiment is made possible through education (to ensure that one becomes an informed consumer and to teach one self-control) and financial resources (to purchase biomedical services and expert advice, and to consume according to one's values, not merely in line with one's basic needs), then these norms will remain available only to those in middle- and upper-class positions.

Furthermore, while middle-class women embark on motherhood with a variety of personal and structural privileges that permit them a greater range of choices than lower-class women, it is important to remember the ways in which these choices, as well as those of lower-class mothers, are shaped by the fact of living in a neoliberal culture. The indirect action of state and capitalist power on mothers' bodies and body-care practices may be more apparent as it works on poor and working-class women, but middle-class mothers are brought under its gaze as well. With their dedication to expert knowledge—shaped, in part, by social discourses about

“total mothering” (Wolf 2011), “intensive mothering” (Hays 1996), and the like (discourses that, it should be noted, still let fathers off the hook for childrearing responsibilities)—middle-class mothers are drawn in “by way of the persuasion inherent in its truths, the anxieties stimulated by its norms, and the attraction exercised by the images of life and self it offers to us” (Rose 1990: 10). As these concerns become tied to social status and class mobility, middle-class mothers become slaves to expertise, albeit ones who are convinced of their freedom.

The climate within which middle- and lower-class mothers strive to nurture their children’s health, development, and self-care values is, thus, much larger than the maternal embodiment period. These projects take part in a culture that does less and less to publicly support the work of raising a child and staying healthy, while placing ever higher moral value on the ability to do these things for oneself. It is within this context that the middle-class “mommy wars”—bitter debates about the wisdom of working for pay or staying at home with young children, often including ideological arguments over breastfeeding or childrearing strategies more broadly—have been heavily reported within popular media and the blogosphere. While many have argued that the “mommy wars” are overhyped, reflecting journalistic fascination with mothering ideology more so than real arguments between actual mothers, their persistence as a cultural phenomenon is significant. So long as body cultivation and care are valued not just for their health benefits but for their moral superiority, and so long as the responsibility for these projects continues to fall almost exclusively on mothers, the trope of the “mommy wars”—and the intense scrutiny and judgment to which mothers across classes are subjected—is unlikely to fade.

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APPENDIX A

Figure 1: “My Shopping Cart. My Rules. Buy more fruits and vegetables.” (California Department of Public Health – Champions for Change 2010; photo by author)



Figure 2: “My Budget. My Rules. Eat right when money’s tight.” (California Department of Public Health – Champions for Change, 2010; photo by author)



Figure 3: “Tightening Your Belt Doesn’t Have to be All Bad” (Florida Department of Agriculture, 2010; photo by author)



Figure 4: “Be a Positive Role Model...Make Healthy Choices!” (Florida WIC, 2010; photo by author)

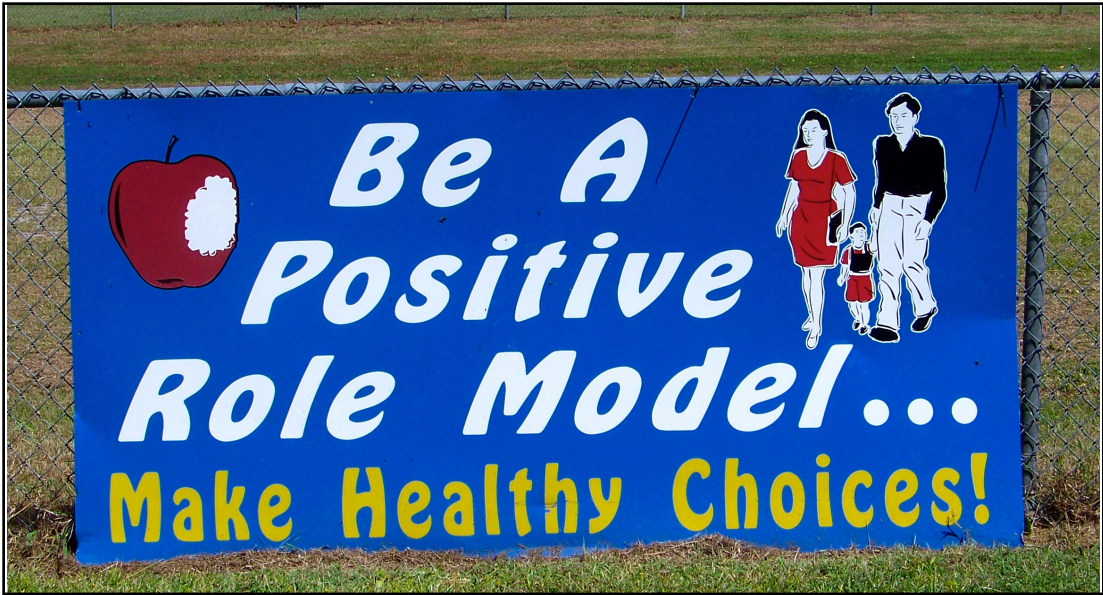
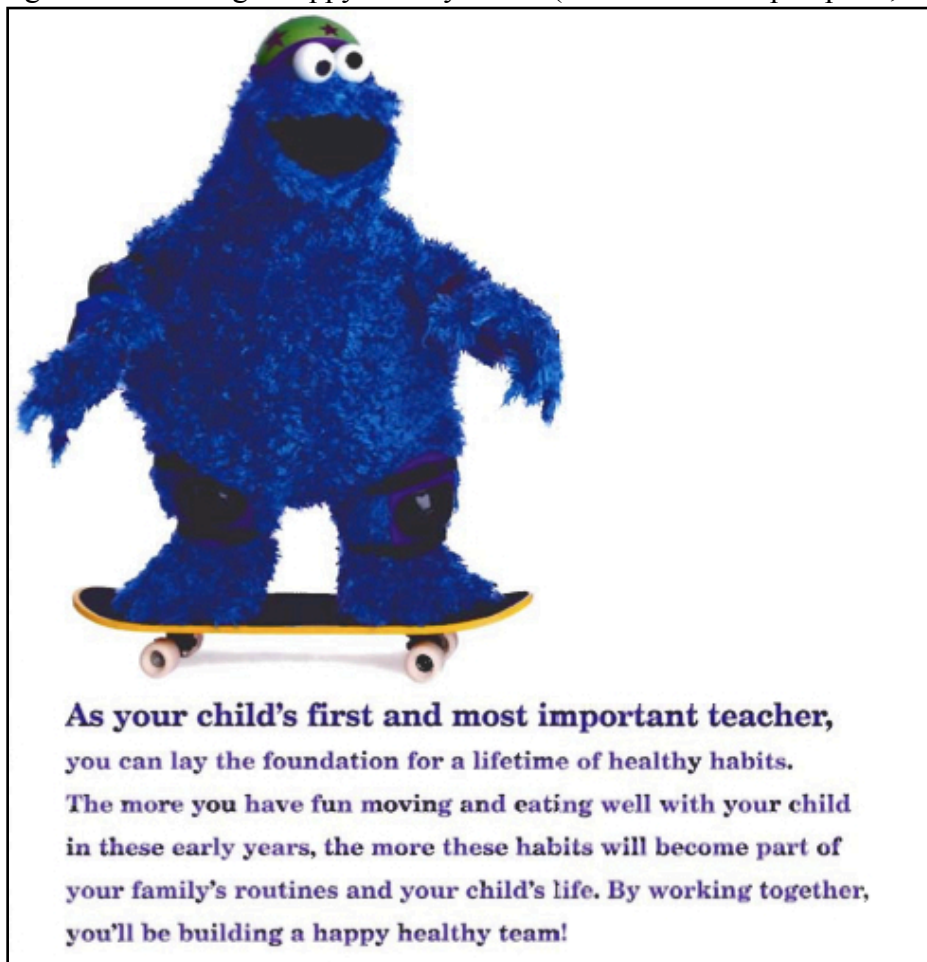


Figure 5: “Parents are Children’s First Teachers” (Florida WIC, 2010; photo by author)



Figure 6: “Building a happy healthy team” (California WIC pamphlet, 2010)



APPENDIX B

Middle Class	State	Education	Currently employed?	Household income	Race / ethnicity	Age	Marital status	Number of children
Amy	California	College	No	\$150,000	Asian	35	Married	2
Anya	California	College	Yes	105,000	White	40	Married	1
Bree	California	Graduate	No	300,000	White	33	Married	2
Brita	California	College	Yes	200,000	White	35	Married	1
Charlotte	California	Graduate	Yes	40,000	White/Asian	32	Married	1
Fiona	California	College	Yes	100,000	White	39	Married	2
Greta	California	Graduate	No	400,000	White	40	Married	2
Lara	California	Graduate	Yes	240,000	White	40	Married	2
Misty	California	Graduate	Yes	230,000	White	31	Married	1
Nadia	California	Graduate	Yes	90,000	White	36	Married	1
Stephanie	California	Graduate	Yes	130,000	White	32	Married	2
Sue	California	Graduate	Yes	85,000	White/Latina	29	Married	1
Suzanne	California	Graduate	No	75,000	White	35	Married	1
Theresa	California	Graduate	Yes	75,000	White	33	Married	2
Alison	Florida	College	Yes	80,000	White	29	Married	1
Amanda	Florida	Graduate	No	70,000	White	30	Married	1
Diane	Florida	Graduate	No	100,000	White	37	Married	2
Emily	Florida	Graduate	No	115,000	White	31	Married	1
Hillary	Florida	Graduate	No	45,000	White	26	Married	1
Isabel	Florida	Graduate	No	170,000	Latina	35	Married	3
Jessie	Florida	Graduate	Yes	80,000	White	31	Married	1
Joan	Florida	Graduate	No	85,000	White	38	Married	2
Kimberly	Florida	College	No	70,000	White	30	Married	3
Lori	Florida	Graduate	Yes	90,000	White	29	Married	1
Lucy	Florida	College	Yes	90,000	White	33	Married	0 (pregnant)
Mackenzie	Florida	Graduate	Yes	90,000	White	30	Married	1
Masha	Florida	Graduate	No	100,000	White	34	Married	3
Michelle	Florida	College	No	65,000	White	29	Married	2
Miranda	Florida	College	Yes	155,000	White	36	Married	1
Rae	Florida	College	Yes	115,000	White	23	Married	1

Mixed Class (currently middle)	State	Education	Currently employed?	Household income	Race / ethnicity	Age	Marital status	Number of children
Dharma	California	Some college	Yes	120,000	White	50	Married	1
Juana	California	Graduate	Yes	90,000	Latina	29	Married	1
Kristen	California	College	Yes	85,000	White	38	Unmarried	2
Lee	California	Graduate	Yes	140,000	White	30	Married	1
Cass	Florida	Some college	Yes	60,000	White	33	Married	1
Louise	Florida	Some college	No	45,000	White	36	Married	2
Mixed Class (currently lower)								
Gita	California	College	No	30,000	South Asian	27	Married	1
Annie	Florida	College	No	35,000	White	29	Married	2
Christine	Florida	Graduate	Yes	35,000	White	37	Married	3
Dani	Florida	Some college	Yes	10,000	White	24	Unmarried	1
Frankie	Florida	College	Yes	20,000	White	32	Unmarried	1
Ji-Eun	Florida	Graduate	No	20,000	Asian	35	Married	3
Nicki	Florida	College	Yes	40,000	White	30	Married	2
Noura	Florida	College	No	0	White	23	Unmarried	1
Lower Class								
Becky	California	High school	Yes	10,000	White	26	Married	2
Gaby	California	Some college	Yes	25,000	Latina	29	Married	1
India	California	Some college	No	5,000	Black	20	Unmarried	1
Jasmine	California	Some college	No	0	Black	34	Unmarried	5
Mercedes	California	High school	No	25,000	Latina	19	Unmarried	1
Nicole	California	Some college	Yes	15,000	Black	22	Unmarried	1
Paz	California	High school	No	0	Latina	28	Divorced	8
Rosa	California	Some high school	No	0	Latina	19	Unmarried	1
Shontel	California	High school	No	0	Black	20	Unmarried	2
Tina	California	Some college	Yes	20,000	Black	40	Separated	1

Lower Class (continued)	State	Education	Currently employed?	Household income	Race / ethnicity	Age	Marital status	Number of children
Chevonne	Florida	Some college	Yes	25,000	Black	23	Unmarried	2
Dawn	Florida	High school	No	35,000	White	33	Married	8
Grace	Florida	High school	Yes	15,000	White	20	Unmarried	1
Janie	Florida	High school	No	0	Black	21	Unmarried	0 (pregnant)
Jolene	Florida	Some college	No	35,000	White	29	Married	3
Kathryn	Florida	High school	Yes	20,000	White	24	Unmarried	2
Kiara	Florida	Some high school	No	0	Black	20	Unmarried	1
LaDonna	Florida	High school	Yes	15,000	Black	26	Unmarried	2
Lynne	Florida	High school	No	15,000	White	27	Unmarried	3
May	Florida	Some high school	No	Not given	Black	49	Married	3
Patrice	Florida	Some high school	No	0	Black	36	Unmarried	4
Robertta	Florida	High school	No	0	White	25	Unmarried	4
Sarah	Florida	Some college	No	5,000	White	21	Unmarried	1
Shawna	Florida	Some college	Yes	10,000	Black	21	Unmarried	0 (pregnant)
Trisha	Florida	Some college	No	20,000	White	25	Married	2
Vanessa	Florida	Some college	No	30,000	White	25	Married	2