

Accepted Manuscript

Contested moral landscapes: Negotiating breastfeeding stigma in breastmilk sharing, nighttime breastfeeding, and long-term breastfeeding in the U.S. and the U.K.

Cecilia Tomori, Aunchalee L. Palmquist, Sally Dowling



PII: S0277-9536(16)30513-5

DOI: [10.1016/j.socscimed.2016.09.014](https://doi.org/10.1016/j.socscimed.2016.09.014)

Reference: SSM 10839

To appear in: *Social Science & Medicine*

Received Date: 7 June 2016

Revised Date: 8 September 2016

Accepted Date: 9 September 2016

Please cite this article as: Tomori, C., Palmquist, A.L., Dowling, S., Contested moral landscapes: Negotiating breastfeeding stigma in breastmilk sharing, nighttime breastfeeding, and long-term breastfeeding in the U.S. and the U.K., *Social Science & Medicine* (2016), doi: 10.1016/j.socscimed.2016.09.014.

This is a PDF file of an unedited manuscript that has been accepted for publication. As a service to our customers we are providing this early version of the manuscript. The manuscript will undergo copyediting, typesetting, and review of the resulting proof before it is published in its final form. Please note that during the production process errors may be discovered which could affect the content, and all legal disclaimers that apply to the journal pertain.

Contested moral landscapes: Negotiating breastfeeding stigma in breastmilk sharing, nighttime breastfeeding, and long-term breastfeeding in the U.S. and the U.K.

Cecilia Tomori, PhD¹, Aunchalee L. Palmquist, PhD, IBCLC², Sally Dowling, PhD, MPH, MFPH³

¹ Johns Hopkins Bloomberg School of Public Health, Baltimore, Maryland, USA

² Elon University, Elon, North Carolina, USA

³ University of the West of England, Bristol, United Kingdom

Corresponding author:

Cecilia Tomori, PhD

Johns Hopkins Bloomberg School of Public Health

Department of Epidemiology

615 N. Wolfe Street, E6648, Baltimore, Maryland, 21205, USA

Email: ctomori1@jhu.edu

1 Abstract

2

3 Recent public health breastfeeding promotion efforts have galvanized media debates about
4 breastfeeding in wealthy, Euro-American settings. A growing body of research demonstrates
5 that while breastfeeding is increasingly viewed as important for health, mothers continue to
6 face significant structural and cultural barriers. Concerns have been raised about the
7 moralizing aspects of breastfeeding promotion and its detrimental effects on those who do not
8 breastfeed. Far less, however, is known about the moral experiences of those who pursue
9 breastfeeding. This study draws together research on breastmilk sharing (2012-2016) and
10 nighttime breastfeeding from the U.S. (2006-2009), and long-term breastfeeding from the
11 U.K. (2008-2009) from three ethnographic projects to address this gap. Comparative analysis
12 of these cases reveals that while breastfeeding is considered ideal infant nutrition, aspects of
13 its practice continue to evoke physical and moral danger, even when these practices are
14 implemented to facilitate breastfeeding. Breastmilk sharing to maintain exclusive breastmilk
15 feeding, nighttime breastfeeding and bedsharing to facilitate breastfeeding, and breastfeeding
16 beyond the accepted duration are considered unnecessary, unhealthy, harmful or even deadly.
17 The sexual connotations of breastfeeding enhance the morally threatening qualities of these
18 practices. The cessation of these “problematic” breastfeeding practices and their replacement
19 with formula-feeding or other foods is viewed as a way to restore the normative social and
20 moral order. Mothers manage the stigmatization of these breastfeeding practices through
21 secrecy and avoidance of health professionals and others who might judge them, often
22 leading to social isolation. Our findings highlight the divide between perceptions of the ideal
23 of breastfeeding and its actual practice and point to the contested moral status of
24 breastfeeding in the U.S. and the U.K. Further comparative ethnographic research is needed

25 to illuminate the lived social and moral experiences of breastfeeding, and inform initiatives to
26 normalize and support its practice without stigmatizing parents who do not breastfeed.

27

28

29 **Key Words**

30 United States; United Kingdom; breastfeeding; stigma; breastmilk sharing; nighttime

31 breastfeeding; bedsharing; long-term breastfeeding

32

33

34

ACCEPTED MANUSCRIPT

35 Introduction

36 Scientific research and global advocacy campaigns have led to growing attention to
37 breastfeeding's impact on health (Rollins et al., 2016). The emphasis on "health benefits",
38 however, signals contemporary perceptions of breastfeeding as extraordinary, measured
39 against cultural norms of infant feeding with artificial milk substitutes (Berry & Gribble,
40 2008; Stuebe, 2009; Wiessinger, 1996). In many Euro-American settings intergenerational
41 breastfeeding knowledge has been lost, there is limited structural or sociocultural
42 breastfeeding support, and milk substitutes remain the primary source of nutrition over the
43 course of infancy (Hausman et al., 2012; McFadden et al., 2016; Rollins et al., 2016; Victora
44 et al., 2016). Moreover, both the content and form of breastfeeding promotion remain
45 controversial. Although most experts agree that breastfeeding, reflecting species-specific
46 mammalian infant feeding adaptations, is valuable to maternal, infant, and community health
47 even in high-income countries (Victora et al., 2016), the scientific evidence supporting
48 breastfeeding promotion in wealthy settings has been repeatedly challenged both in scholarly
49 and media outlets (Colen & Ramey, 2014; Faircloth, 2015; Jung, 2015; Oster, 2015; Rosin,
50 2009; J. B. Wolf, 2011). Additionally, there is growing concern over breastfeeding promotion
51 messages that equate good motherhood with individual mothers' breastfeeding, and fail to
52 consider the pervasive structural and sociocultural barriers to breastfeeding, thereby
53 stigmatizing and marginalizing those who lack resources and support or do not wish to
54 breastfeed (Hausman, 2003, 2011; Lee, 2007, 2008; Murphy, 1999, 2000; Tomori, 2014; J. B.
55 Wolf, 2007, 2011). There is growing recognition, as reflected by the recent Lancet
56 Breastfeeding Series, that a broader societal commitment is needed to enable and support
57 breastfeeding, and that breastfeeding plays a key role in reducing existing inequalities
58 (Rollins et al., 2016, 491). Nevertheless, calls for curtailing or ending breastfeeding
59 promotion in high-income countries signal the culturally contested status of breastfeeding

60 (Colen & Ramey, 2014; Faircloth, 2015; Lee, 2011; Oster, 2015; Rosin, 2009; J. B. Wolf,
61 2011).

62 While the potential negative impact of breastfeeding advocacy has received a wealth
63 of attention, far less work addresses the diversity of moral experiences of breastfeeding
64 (Faircloth, 2013; Hausman, 2007; Ryan et al., 2010; Smale, 2001; Tomori, 2014). Yet a
65 substantial body of research documents that stigmatization remains a powerful barrier to
66 breastfeeding, much of which addresses breastfeeding in public spaces - a focus area of
67 recent breastfeeding activism (Boyer, 2011, 2012; Grant, 2016; Mulready-Ward & Hackett,
68 2014; Stearns, 2011; Thomson et al., 2015). In this paper we draw on our collective long-
69 term research from the U.S. and U.K to highlight practices that facilitate mothers'
70 breastfeeding and babies getting breastmilk, yet remain highly controversial: breastmilk
71 sharing, nighttime breastfeeding, and long-term breastfeeding. We employ a comparative
72 case studies approach to demonstrate that many aspects of breastfeeding practice beyond
73 feeding young infants in public spaces continue to be perceived as socially and morally
74 problematic and remain stigmatized. We argue that these examples, drawn from close study
75 of mothers' lived experiences, provide important insight into the contested cultural
76 landscapes of infant feeding in these and similar settings, where breastfeeding has been
77 reintroduced as part of public health advocacy, but divisions remain between the growing
78 cultural ideal of breastfeeding to ensure health and its everyday practice.

79 In evoking the concept of stigma, we build on a rich body of medical anthropological
80 scholarship based on Goffman's work, which emphasizes social relationships rather than
81 individual identities or subjectivities (Kleinman, 1997; Kleinman & Hall-Clifford, 2009;
82 Yang et al., 2007). Kleinman and colleagues emphasized the importance of treating stigma
83 not as an individual property, but rather a fundamentally interpersonal process constructed in
84 and through social relationships. These authors argued that stigma is inextricably bound to

85 moral experience – it threatens “what matters most” to people (Yang et al., 2007).
86 Furthermore, the analysis of stigmatization unites the “physical-social-emotional-cultural
87 domains,” facilitating an embodied, experiential analysis of social relationships. Accordingly,
88 we highlight instances where mothers anticipate and encounter moral judgement in their
89 breastfeeding journeys. While we incorporate descriptions of the emotional experience of
90 encountering moral judgement, our focus remains on broader sociocultural moral norms of
91 infant feeding rather than on the psychological aspects of these processes as exemplified by
92 recent work on shame in infant feeding experiences (Thomson et al., 2015).

93 The history of breastfeeding, its contemporary practice, and sociocultural context in
94 the U.S. and the U.K. has been documented by social scientists and public health researchers
95 (Apple, 1987; P. Carter, 1995; Dykes, 2006; Hausman, 2003; Rollins et al., 2016; Tomori,
96 2014; J. H. Wolf, 2001). These settings share important sociohistorical trends: the
97 historically normative practice of breastfeeding through at least the 19th century and early 20th
98 centuries, the decline and eventual replacement of breastfeeding with artificial milk
99 substitutes in the 20th century, and grass roots and later public health efforts to encourage
100 breastfeeding beginning in the second half of the 20th century. A key difference, however, is
101 the availability of significantly more structural support for breastfeeding in the U.K., with
102 paid maternity leave, universal access to midwifery care, a substantial number of births
103 taking place at Baby Friendly Hospitals, and legislation encompassing some provisions of the
104 International Code of Marketing of Breastmilk Substitutes (UNICEF, 2015; United Kingdom
105 Government, 2015; World Health Organization, 1981). Although the Patient Protection and
106 Affordable Care Act of 2010 has greatly improved access to health care and implemented
107 new accommodations for breastmilk expression at the workplace, the U.S. is an outlier
108 among wealthy industrial nations for its lack of universal health care coverage, paid parental
109 leave, subsidized and on-site childcare, and tighter regulation of the infant formula industry

110 (Tomori, 2014). Despite the lack of structural support, however, the U.S. has been much
111 more successful in improving the prevalence of breastfeeding over the course of infancy
112 (Centers for Disease Control and Prevention, 2016) while rates in the U.K. are markedly
113 lower after initiation (McAndrew et al., 2012).

114 Breastfeeding remains a public health priority in both settings (Department of Health
115 and Human Services, 2010; Public Health England, 2014). Premature weaning is particularly
116 problematic in the U.K., where many interpret guidance to breastfeed exclusively for six
117 months as setting an upper limit for breastfeeding (Dowling & Brown, 2013; McAndrew et
118 al., 2012). Although initiation rates are high, most recent data suggest that fewer than half of
119 all babies in the U.K. are still breastfed by 6 weeks (Public Health England, 2016)
120 representing a decline since the 2010 Infant Feeding Survey (McAndrew et al., 2012). These
121 data suggest that formula feeding remains the most common form of infant feeding over the
122 course of the first year of infancy. Recent survey data also indicate that despite legal
123 protections considerable cultural discomfort remains with public breastfeeding, with over a
124 third of mothers hesitant to breastfeed in public (Public Health England, 2015) Mixed
125 breastfeeding and formula feeding also become more common over the course of the first
126 year in the U.S., and in many communities neither exclusive breastfeeding (Cartagena et al.,
127 2014; Morrison et al., 2008) nor breastfeeding in public (Fischer & Olson, 2014;
128 Mitchell-Box & Braun, 2012) are common cultural practices. Moreover, both settings share
129 disparities in breastfeeding by socioeconomic status, education, race and ethnicity
130 (McAndrew et al., 2012; Oakley et al., 2013), but ethnic minorities are more likely to
131 breastfeed in the U.K. (Griffiths & Tate, 2007; McAndrew et al., 2012), whereas many racial
132 and ethnic minorities in the U.S., especially African American women, are considerably less
133 likely to breastfeed than white women (Centers for Disease Control and Prevention, 2016).
134 Finally, although cultural support and breastfeeding activism has increased in both settings

135 breastfeeding remains controversial, as described above. Our study investigates how the
136 stigmatization of breastfeeding shapes breastfeeding experiences in societies where
137 breastfeeding is promoted but formula feeding remains common and structural factors inhibit
138 breastfeeding.

139

140 **Methods**

141 This analysis draws on three different research projects. All identifying information
142 was removed and pseudonyms are used in quotations for each case study.

143 Study 1. Breastmilk sharing: This report draws on data collected as part of a mixed-methods,
144 multi-sited ethnographic study approved by the Institutional Review Board of Elon
145 University by [author 2] of breastmilk sharing between 2012-2016. The study included
146 participant observation in four hospitals, two community-based healthcare practices, and
147 home-visits with families in milk sharing communities across the U.S; semi-structured
148 telephone interviews with milk sharing donors and recipients (n=165); and ethnographic
149 interviews with donors and recipients, their spouses/partners, other family members, and
150 friends as well as healthcare providers in seven different milk sharing communities across the
151 U.S. Ethnographic data were triangulated with observational data, fieldnotes, and narratives
152 to ground interpretations of the data. The subsample of participants in the ethnographic study
153 reflect the representative demographic characteristics of the general study population as
154 reported previously (Palmquist and Doehler 2014), and are primarily college educated,
155 middle-income, white cisgender women.

156 Study 2, Nighttime breastfeeding: This discussion is drawn from a two-year ethnographic
157 study of breastfeeding by [author 1] conducted with Institutional Review Board approval
158 from the University of Michigan between 2006-2008 with additional follow-up in 2009 in the
159 Midwestern U.S., full details of which have been described elsewhere (Tomori, 2014).

160 Briefly, the study focused on 18 middle-class, primarily white, first-time mothers and their
161 families who intended to breastfeed, who were followed from their second trimester of
162 pregnancy through their first year postpartum using extensive ethnographic participant
163 observation and in-depth interviews in participants' homes. Additional participant
164 observation and interviews were carried out at childbirth and breastfeeding-related education
165 and events and with childbirth/breastfeeding professionals. These ethnographic materials
166 formed the basis of rigorous anthropological analysis, and discussion of breastfeeding and
167 infant sleep in cross-cultural, evolutionary, historical and feminist perspectives.

168 Study 3, Long-term breastfeeding: This study was carried out with approval from the
169 Research Ethics Committee of the University of the West of England Bristol by [author 3]
170 between January 2008 and April 2009 to explore the experiences of women who breastfeed
171 long-term in the U.K using micro-ethnographic methods. Participant observation with over
172 80, mostly white women took place in one La Leche League (LLL) group, held in an affluent
173 area and in two community groups, held in disadvantaged areas with low breastfeeding rates.
174 Additionally, 10 in-depth interviews (face-to-face and online) were carried out with women
175 who had breastfed 15 children in total, from 4 months to 6 and a half years. Data were
176 analysed thematically and in relation to the concepts of liminality, stigma and taboo,
177 described in detail elsewhere (Dowling, 2011; Dowling & Pontin, 2015).

178

179 **Results**

180 Breastmilk sharing in the U.S.

181 Allomaternal nursing, the provisioning of breastfeeding or breastmilk by other women
182 within social groups, is a cross-culturally well-documented cooperative infant care practice,
183 whose cultural significance is varied and context-specific (Cassidy & El-Tom, 2010; Fildes,
184 1988; Hewlett & Winn, 2014; Shaw, 2004b; Thorley, 2011). While the WHO/UNICEF

185 (World Health Organization, 2003) recognizes cup-feeding of freshly expressed human milk
186 or breastfeeding by another healthy lactating woman, or pasteurized banked donor human
187 milk (if available) as alternatives when a mother's milk is unavailable or requires
188 supplementation, in the U.S. (along with Canada, Australia, France), medical agencies advise
189 against peer-to-peer breastmilk sharing, citing risks of communicable diseases, exposures to
190 medications and substances, and contamination due to unhygienic storage and handling
191 (Palmquist & Doehler, 2014). Such risk discourses reflect anxieties regarding the moral lives
192 of mothers, who may be giving away milk polluted through sexual activity, medications or
193 other substances, and unsanitary milk expression, storage, and handling practices (Hausman,
194 2011). The history of peer-to-peer milk sharing and related controversies have been explored
195 elsewhere (Akre et al., 2011; S. K. Carter et al., 2015; Cassidy, 2012; Geraghty et al., 2011;
196 Gribble, 2014a, b; Gribble & Hausman, 2012; Palmquist & Doehler, 2014). Here, we focus
197 on how primary caregivers who seek and use shared breastmilk navigate the moral dilemmas
198 they encounter in their everyday lives.

199 A majority of milk sharing recipients in our study were breastfeeding mothers who
200 had given birth to a healthy full-term baby (Palmquist & Doehler, 2014, 2015). Others
201 included transgender birthparents, parents whose child was born via surrogacy, adoptive
202 parents, foster parents, and primary caregiving grandparents. Among breastfeeding
203 birthmothers seeking breastmilk via milk sharing was nearly always a response to an
204 unexpected lactation crisis. For instance, mothers whose premature babies received banked
205 donor human milk in the neonatal intensive care unit (NICU) were often highly motivated to
206 seek donor milk post-discharge. A few mothers gathered donations of shared milk based on
207 prior experiences of lactation insufficiency. Adoptive parents or parents awaiting the birth of
208 their baby via surrogacy were also more likely to seek shared milk. Below we focus on the
209 experiences of cisgender birthmothers who intended to breastfeed, initiated breastfeeding,

210 and were diagnosed with lactation insufficiency by a lactation consultant or pediatrician.
211 These mothers typically had several weeks to months of intensive lactation support and
212 intervention throughout their breastfeeding journey. Some required a brief period of
213 supplementation, while others ceased breastfeeding and relied completely on milk sharing
214 and/or formula-feeding. Over half of breastmilk recipients in the general study population
215 continued breastfeeding and/or breastmilk expression during the period of breastmilk sharing
216 (Palmquist & Doehler, 2014).

217 The experience of lactation insufficiency was extremely difficult and isolating,
218 particularly for breastfeeding birthmothers. Their breastfeeding grief often went unrecognized
219 by people who implied that perhaps they had not *“tried hard enough”* and invalidated by
220 others who declared that formula was *“just as good”* as breastmilk. Many family, friends,
221 and health professionals failed to sympathize with mothers’ grief over the loss of
222 breastfeeding and their wish to provide human milk for their baby.

223 Regardless of circumstances, formula was the unquestioned, expected, and convenient
224 alternative to a mother or parent’s own milk. Lindsey described her husband’s fatigue with
225 lactation insufficiency following the birth of their second child, *“...we nursed her and*
226 *weighed her, and she retained like two tenths of an ounce on one side and some ridiculous,*
227 *like zero or one tenth of an ounce on the other side. My husband just looked at me and said,*
228 *when can we give this baby a bottle?”* Another mother struggling with pain due to vasospasm
229 and untreated post-partum depression recalled her obstetrician’s reaction, *“Well, why don’t*
230 *we just use formula? This is painful!”*

231 In contrast to formula use, milk sharing decisions involved information seeking and
232 careful consideration of the possible risks, benefits, costs, and implications. Amanda
233 described a discussion with her husband, *“We wanted to get the milk from someone that we*
234 *sort of feel a connection with, and you know, we feel like it’s safe to take it from them, ‘cause*

235 *in the back of our heads we did have those concerns about, you know, it's a bodily fluid and,*
236 *what about infectious disease?"* These initial concerns, however, were swiftly assuaged by
237 risk mitigation practices, relationships of trust within milk sharing circles, and witnessing
238 their babies thriving. These positive experiences directly contradicted the stigmatizing public
239 health risk messages with which they were confronted, which undermined their confidence in
240 such messaging. As Elise described, *"It is kind of like being afraid of getting struck by*
241 *lightning so refusing to go outside. It's just very unlikely in my opinion."*

242 While proximity and familiarity facilitated information gathering needed to mitigate
243 milk sharing risks, intimacy just as often threatened close relationships by transgressing
244 different boundaries between donors and recipients. Donors sometimes avoided offering milk
245 to someone they knew who was struggling with low milk supply for fear of exacerbating
246 feelings of inadequacy. Recipients often worried about being stigmatized by family members
247 or close friends. Brooke noted the pain she experienced when her request for a friend's milk
248 was rejected, *"Well, the most disappointing person was my best friend. When I had Harry,*
249 *she had a baby two weeks after me. And it made me so sad, super sad, because she said no,*
250 *because she felt like her husband would have been weirded out. And I knew that if the shoe*
251 *had been on the other foot, I would have pumped for her everyday."* The husband's reaction
252 evoked his discomfort and control over sharing this (sexualized) substance.

253 Recipients' spouses/partners were generally supportive of milk sharing, but other
254 family members' views were more varied, for example, *"You know, we have some family*
255 *members that expressed some concerns that though 'Oh, well it's not screened, it's too*
256 *casual, it may not be safe".* In response, recipients quickly adapted by carefully choosing
257 whom they would tell about the milk sharing, *"We have a specific family member that we are*
258 *keeping it hushed from, because we don't think she would respond well. I think that she would*
259 *be very critical. I think that she would fear for how much we were putting him in danger*

260 *because we are exposing him to diseases - if she finds out, then fine, but we are not telling*
261 *her.”*

262 Managing stigma in this way was very common among during interactions with
263 health care providers as well. Parents tended to discuss milk sharing only with paediatricians
264 they perceived as non-judgemental or actively supportive. Recipients described their fears of
265 talking to physicians about milk sharing due to worry that they would be subjected to stigma,
266 or worse, reported to child protective services, for instance: *“No, I didn’t tell him*
267 *[paediatrician]. I don’t think he would like it, I mean, he’s not that supportive of breastfeeding*
268 *and was pushing the formula. I mean, he knew I was having trouble with breastfeeding so I*
269 *don’t know what he thinks I’m feeding the baby, but I’m not going to tell him!”* Birth and
270 breastfeeding workers were typically more open to discussing milk sharing, and some even
271 went so far as to facilitate it between families. Even in these cases, stigma of milk sharing
272 within the health care professions forced many to do so in secret, for fear of losing their jobs,
273 losing their licenses, or losing face in their communities of practice.

274 275 Nighttime Breastfeeding in the U.S.

276 Nighttime breastfeeding and bedsharing are controversial in the U.S. Solitary,
277 continuous sleep in a separate room is highly desirable, and voluminous parenting literature
278 espouses various sleep training methods to attain this goal (Tomori, 2014). Until recently
279 infant sleep guidelines, driven by concern about Sudden Infant Death Syndrome (SIDS),
280 reinforced solitary sleeping norms and ignored breastfeeding, even though solitary infant
281 sleep is neither the evolutionary nor the cross-cultural norm (McKenna & McDade, 2005). A
282 growing body of literature documents that breastfeeding reduces the prevalence of SIDS,
283 proximate sleep facilitates breastfeeding, and bedsharing coupled with breastfeeding can be
284 carried out safely (Ball & Volpe, 2013; Blair et al., 2010; McKenna & McDade, 2005).

285 McKenna and Gettler (2016) recently coined the term “breastsleeping” to describe the tight
286 evolutionary and physiological relationship between breastfeeding and infant sleep. Although
287 the most recent guidelines (AAP 2011) recognize the protective roles of proximity (room-
288 sharing) and breastfeeding, they continue to reject bedsharing and lack guidance on safer
289 bedsharing strategies. The larger study documents how parents navigate the recommendation
290 for breastfeeding and solitary infant sleep (Tomori, 2014). Here, we summarize the main
291 sources of stigmatization of nighttime breastfeeding and related bedsharing, or
292 “breastsleeping.”

293 None of the families planned to regularly bedshare prior to the birth of their child, yet
294 nearly all families did so at least periodically during the first few weeks, and nearly half of
295 the families continued to share their beds for some part of the night throughout the year.
296 These arrangements were driven by infants’ need to breastfeed. Infants did not easily sleep on
297 their own; they often fell asleep at the breast, only to awaken when put down in a bassinet or
298 co-sleeper. Often, infants would only be soothed by breastfeeding, initiating another cycle of
299 breastfeeding, falling asleep, putting the baby down, and awakening. Bringing infants into
300 bed enabled mothers to breastfeed while also getting rest, and was particularly helpful for
301 mothers who had a Cesarean section, which limited their mobility, and necessitated complex
302 coordination of feedings between partners.

303 All nighttime arrangements that involved sustained bodily proximity, especially over
304 time, were a source of concern to the parents, their relatives and friends, and were subject to
305 potential medical scrutiny. Some parents expressed their discomfort with bedsharing due to
306 safety concerns raised by pediatric advice, and worries that their baby would get used to
307 sleeping this way. For instance, Bridget’s mother told her, “*You really need to put her down*
308 *‘cause she’s never gonna learn to sleep by herself.’ I got a lot of that. I still get a lot of that*
309 *[small laugh]... that worries me, in the back of my mind, what if she’s never gonna sleep on*

310 *her own and I'm gonna have to hold her forever.*" For some, discomfort was also associated
311 with the sexual connotations of the bed, and the inability to have sex with one's spouse with
312 the baby in the same room. For several parents, these initial concerns led to room-sharing
313 instead of bedsharing, even if they found the latter more convenient. Others overcame these
314 concerns and decided to bring their baby into bed with them regularly. Even among those
315 who were only room-sharing, however, concerns over not conforming to cultural
316 expectations of sleeping through the night in a separate room grew over time, often prompted
317 by questions about their baby's sleep from others.

318 Parents were frequently queried about their baby's sleep by friends, colleagues,
319 medical professionals, and even by strangers. Since questioners assumed that the baby slept
320 in a bassinet or crib, most parents who bedshared chose not to share that the baby slept next
321 to them and nursed throughout the night. Leslie, for instance, told me that she "*brushed*
322 *over*" her sleep practices with colleagues. Leslie already knew that these colleagues were
323 proponents of babies letting babies cry themselves to sleep, and heard them say that another
324 colleague who breastfed and bedshared should "*get the baby out of their bed*" because the
325 baby was "*controlling*" them. Consequently, Leslie revealed little to prevent judgment and
326 protracted discussion.

327 Medical professionals were a key source of stigmatization of breastsleeping. They
328 considered bedsharing particularly dangerous because of SIDS. This message was driven
329 home to Jocelyn when a pediatrician warned them that "*babies die when they sleep in beds*"
330 (Tomori, 2014, 133). Jocelyn found the doctor's statement and his dramatic description of the
331 demise of babies from bedsharing unsettling, "*I mean, I was just thinking about it today, the*
332 *pediatrician [...] was just like [...] it was really sort of graphic, like putting hands on babies,*
333 *you know.*" This incident, combined with her mother's fears of smothering her own child
334 while bedsharing, had a lasting impact on Jocelyn. When their baby would not sleep on her

335 own, Jocelyn had trouble sleeping either with or without her baby, and ultimately developed a
336 complex part-night bed-sharing/ bassinet sleeping arrangement with her spouse. Parents
337 generally lied about or kept their bedsharing secret from their pediatricians, and often learned
338 that their friends and family similarly did so. They also tried to find breastfeeding-supportive
339 pediatricians who were more open-minded about bedsharing. While these physicians did not
340 criticize breastsleeping, they offered no guidance on safe bedsharing.

341 Medical professionals often echoed others' concerns about the need for sleep-training
342 and night-weaning. For instance, Corinne's paediatrician repeatedly recommended that she
343 separate sleep from breastfeeding, put her baby down while drowsy to facilitate sleep, and
344 implement sleep-training to develop his "*self-soothing*" skills. Even though Corinne "*made a*
345 *decision that I wasn't going to do that [sleep training],*" she doubted herself after her recent
346 visit: "*I thought about it more seriously after the pediatrician kind of made it sound like I*
347 *should be doing that.*" Corinne ultimately decided not to follow her pediatrician's advice, and
348 she avoided the topic with her doctor. Carol received similar advice from a nurse about the
349 importance of falling asleep alone and not picking up her baby at night in a local hospital's
350 new mothers' group she attended at two months postpartum. Since she disagreed and
351 bedshared to facilitate nighttime breastfeeding, she did not divulge her practices, nor returned
352 for later meetings. Calls to "sleep-train" and let the baby "cry-it-out" - left to cry without
353 being picked up until they fell asleep - increased over time, making some parents question
354 their nighttime practices and try this method, even if they were uncomfortable with it.

355

356 Long-term breastfeeding in the U.K

357 It is unusual in the U.K. to see breastfeeding beyond the first six months, and
358 especially after a year. Research on U.K. women's experiences of breastfeeding beyond six
359 months, considered long-term in this setting (Faircloth, 2010a, b, 2011; Healthtalkonline,

2011), indicates that similar to the U.S., they experience less support from 6–8 months and increasing attempts at persuasion to wean (Gribble, 2008; Stearns, 2011). In these unsupportive sociocultural situations women often hide breastfeeding (Buckley, 2001; Gribble, 2008; Rempel, 2004). Participants in this study, who breastfed for a range of time from birth up to six and a half years, faced multiple sources of moral judgment, from their own reactions to disapproval from others, which often led to the feeling of social isolation.

Few participants intended to breastfeed long-term; most planned to breastfeed, and continuing was *'just a gradual thing that happen[ed]...'* (Josie). Comments about long-term breastfeeding, such as *'I'd often sort of felt uncomfortable at the idea of feeding older babies...and toddlers'* (Jane) and *'I never could have imagined breastfeeding a four-year-old child'* (Sarah) demonstrate that they had not envisioned themselves continuing long-term. Indeed, mothers found breastfeeding long-term *'shocking'* or *'surprising'* before they themselves breastfed long-term (Dowling and Pontin, 2015). Mothers ultimately overcame their own internalized stigmatization of long-term breastfeeding and became committed to long-term breastfeeding; strongly believing it facilitated their child's physical and emotional health, but described needing to be determined, strong-willed or courageous to continue against societal norms.

This commitment was hard for others to understand, however and they often received comments such as: *'What are you still doing that for?'* (LLL meeting participant) and *'lots of family saying "oh, you're a big boy now, you don't need that"...*' (Mandy). Partners and some extended families were supportive of long-term breastfeeding, but mothers, mothers-in-law, or older relatives often expressed criticism. For instance, Josie explained *"It's mainly my mum and my mother-in-law because they're more vocal about it. I'm sure there's other people that find it difficult...in my friendship groups but it's my family that I have the most difficulty with..."* (author's emphasis). One woman commented in a LLL meeting that

385 visiting her mother with her two-year-old son had ceased because continued breastfeeding
386 was said by her to be '*disgusting*'. Others suggested that the behaviour was "unnatural" - '*you*
387 *can't tell...because people think it's weird*', (Sam) - that women breastfed to fulfil their own
388 desires or that '*people worry that you are doing it to keep them [the child] a baby*' (Jane).

389 Health professionals were not perceived to be supportive of long-term breastfeeding.
390 Consequently, most participants ignored professional advice and some stopped consulting
391 them altogether, encouraged by more experienced breastfeeders in LLL meetings. Sarah
392 described an extremely negative experience when she took her daughter, who was about one-
393 year old at the time, to the hospital for an emergency consultation, "*In a room with a poster*
394 *advocating breastfeeding on the door the nurse proceeded to complain...and snapped at the*
395 *doctor that I was not cooperating because I was breastfeeding*"

396 The majority of interview participants discussed others' discomfort associated with
397 breastfeeding older boys. For instance, Tina's mother-in-law said, "*...ooh ooh, breastfeeding*
398 *a boy, ooh it's a bit odd, isn't it?*". Even if no words were spoken, mothers were aware that
399 this might be seen as a sexual act. Christine, whose son was breastfed to six and a half,
400 described how her community's disapproval led to an investigation by social services,
401 "*people in the village turned against me, and twice reported me to social services. The first*
402 *time...it was neighbours disapproving of our lifestyle. The second time...we had to endure a*
403 *full initial assessment. One of the items...reported was that I was still breastfeeding...*"

404 Unexpectedly, the women in this small study said that they felt comfortable
405 breastfeeding in public, even when breastfeeding 3-year-old or older children, and would not
406 conceal their breastfeeding (although some selectively shared this information). Almost all,
407 however, described feeling more awkwardness from the second part of the first year onwards.
408 Jess, who was breastfeeding her three-year-old, described her own internal change in
409 response to a growing awareness of others' discomfort: "*this is something which has been*

410 *shifting for me in the last few months. I feel less comfortable about it, and it is because of*
411 *potential reactions.”* (author’s emphasis). Although participants did not experience explicit
412 comments or reactions to breastfeeding in public, they anticipated unpleasant or difficult
413 comments.

414 Despite their stated comfort with breastfeeding in public, the majority of participants
415 talked about ‘being discreet’ as something that was expected of them, and their use of the
416 term suggested a need to protect others from witnessing an older child breastfeeding. They
417 used a range of strategies to feel more comfortable, including only breastfeeding in public
418 with other breastfeeding women, careful positioning of both self and child in public places,
419 and not making eye contact: *‘I just don’t meet people’s eyes on such occasions’* (Jess).

420 For Sam and others there was an obvious tension between professed confidence about
421 breastfeeding in public and their concern with minimizing the anticipated (negative)
422 attention, *‘I just kind of ignore people around me, when I’m doing it...sometimes I do try and*
423 *go in a bit of a quieter place...but you do feel a bit like a spectacle just sat in the middle of a*
424 *room [nursing]’* (Sam). Josie also talked about *‘feeling on display’*. Indeed, it seemed that
425 these women managed their behaviour partly to avoid making other people feel
426 uncomfortable and partly to minimize the impact of others’ negative perception of them.
427 Finally, some felt the need to manage others’ anticipated negative reactions even in their own
428 homes, with private places sometimes also experienced as public: *“when they [her parents,*
429 *who were initially supportive of breastfeeding] came when she was older I felt I had to go*
430 *into a room with her and feed her there. I didn’t find it comfortable in public...”*

431 Many women engaged in long-term breastfeeding experienced social isolation. On-
432 going friendships with mothers who did not breastfeed (who constituted the vast majority of
433 mothers over time) were difficult, partly because their long-term breastfeeding was not
434 supported: *‘I’ve stopped meeting up with friends I know will say anything about it...I’ve given*

435 *up trying to explain it...*’ (woman at LLL meeting). Participants also discussed how their
436 broader parenting decisions, which centered around responding to the child, met with
437 disapproval and little support from family, friends and the wider community. Instead, women
438 sought support from ‘like-minded women’ through groups or from the internet and persisted
439 despite these challenges because of their commitment to breastfeeding.

440

441 **Discussion**

442 Our comparative study of breastmilk sharing, nighttime breastfeeding, and long-term
443 breastfeeding from the U.S. and U.K. elucidates the intricacy of infant feeding decision-
444 making and breastfeeding practices and highlights the conflicted nature of these cultural
445 landscapes wherein the concept of breastfeeding may be associated with ideals of “good
446 motherhood,” but many embodied aspects of breastfeeding practice remain morally suspect
447 and continue to be construed as dangerous. Moreover, the ostensible divide between
448 breastfeeding and formula feeding mothers is blurred by this ethnographic evidence, which
449 attests to the pervasiveness of normative social expectations for formula- and bottle-feeding
450 alongside solitary sleep and early weaning.

451 Mothers in our studies occupy a liminal space in which they breastfeed, but do so in
452 ways that are either not endorsed by biomedicine and/or are deemed socially unacceptable
453 and must manage the stigma associated with their practices, Although most of these mothers
454 possess the socioeconomic and cultural resources that enable them to continue, they find
455 health care provider guidance and social support in their breastfeeding journeys inconsistent
456 or elusive. Breastfeeding has long been a site of paradoxical messages about maternal
457 im/morality and ir/responsibility (Hausman, 2011; Shaw, 2004a; J. H. Wolf, 2001). Our
458 results suggest that formula-feeding not only remains a highly prevalent, but also often the
459 culturally unmarked, normative infant feeding practice in the U.S. and U.K. Breastmilk is

460 idealized in the context of a natal breastfeeding dyad or human milk banking, but milk
461 sharing evokes discomfort and danger. Similarly, breastsleeping, including falling asleep at
462 the breast, nighttime nursing, and bedsharing are considered problematic or inherently
463 dangerous, although these practices are implemented by families to facilitate continued
464 breastfeeding. Sustained breastsleeping becomes more problematic over time, as cultural
465 expectations demand solitary infant sleep. Finally, while breastfeeding before six months is
466 idealized in the U.K., breastfeeding beyond that time becomes increasingly unacceptable.
467 This, too, is perceived as morally threatening, “odd”, “disgusting” and “unnatural” and
468 potentially endangering child wellbeing.

469 The sexualisation of breastfeeding clearly contributes to the stigmatization of each of
470 these practices, reflected by pervasive concerns about the passage of sexually transmitted
471 infections through milk to recipient infants and the intimacies that form via sharing
472 breastmilk, breastsleeping because of the bedroom’s association with sexuality, or
473 breastfeeding older children. Thus, these act of breastfeeding, which constitute forms of
474 resistance against cultural norms for infant feeding, pulls these breastfeeding mothers and
475 other primary caregivers into social spaces, encounters, and conversations in which they are
476 forced to reflect upon and co-construct their social and moral selves (Yang et al., 2007).

477 Since mothers in our studies had not planned to engage in these breastfeeding
478 practices in advance, they often needed to challenge their own internalized stigmatization in
479 order to initiate and continue them while they also underwent intense moral scrutiny and
480 perceived stigmatization from others, including family members, friends, and health
481 professionals. One way they gauged this stigma was by carefully listening to comments in
482 conversations not directly aimed at the mother, leading to growing awareness that their
483 practice was misaligned with social norms and might evoke moral judgment. This increasing
484 sense of discomfort was particularly relevant for breastsleeping and long-term breastfeeding,

485 where stigmatization amplified over time. In order to minimize anticipated stigmatization,
486 parents engaged in classic stigma management strategies (Goffman, [1963] 1986) and
487 concealed their practices, kept them “private”, hid them sometimes even within their own
488 home, or lied about it. If a parent chose to breastfeed in front of others, such as some long-
489 term breastfeeding mothers in the U.K., she might make breastfeeding less visible. When
490 they were unable to or chose not hide these practices, stigmatization often materialized
491 through disapproving comments, which was particularly hurtful when it came from close
492 friends or family members.

493 Health professionals’ perceptions of these breastfeeding practices as “unnecessary” or
494 “dangerous” played a particularly important role in their stigmatization, since professionals
495 were in positions of authority, and could even trigger legal action due to concerns about child
496 endangerment or sexual abuse (a non-existent threat for formula feeding). Even among
497 relatively supportive health professionals, there was little discussion of the stigmatized
498 practices, perhaps to avoid conflict with official guidelines that endorse a categorical
499 prohibition (e.g. milk sharing, bedsharing). Such stigmatization drove parents to hide these
500 breastfeeding practices, preventing opportunities for discussion.

501 Our research is limited by the small sample size of our studies and their focus on
502 mostly middle class, white participants that reflect our ethnographic settings, which likely
503 conferred a degree of protection from the full impact of the stigmatization of breastfeeding.
504 At the same time, appropriately contextualized, long-term ethnographic research is
505 recognized as an excellent method for the analysis of complex cultural issues such as
506 breastfeeding because of this method’s deep engagement with multiple forms of data,
507 including participant observation in multiple settings, informal conversations and interviews,
508 analysed through the prism of various social theoretical constructs (LeCompte & Schensul,
509 1999; Pfeiffer & Nichter, 2008; Van Maanen, 2011). Our ethnographic work can provide an

510 important starting point for other researchers to document the stigmatization of breastfeeding
511 – and infant care – among different groups of mothers and in other settings.

512 Our comparative analysis makes an important contribution to the literature on
513 breastfeeding and stigmatization, which contains few studies that theorize these issues based
514 on ethnographic grounding in women's experiences, and highlights the paradoxical moral
515 position that breastfeeding continues to have in the U.S. and the U.K. Although promotion
516 efforts have increased the acceptability of breastfeeding, it is far from an unquestioned norm.
517 Indeed, breastfeeding continues to have a contradictory and contested moral status, where its
518 effects on health are valued, while aspects of its practice evoke moral and physical danger
519 (Douglas, 1966). The effects of this stigmatization are acutely felt by parents, who must
520 manage their own internalized stigmatization and that of others, in order to engage in these
521 practices. They manage this stigma through secrecy, and avoidance of people who might
522 judge them, ultimately leading to considerable social isolation for many mothers and their
523 families. The continued stigmatization of the practice of breastfeeding and its consequences
524 directly undermine the goals of breastfeeding promotion and advocacy to normalize
525 breastfeeding as a cultural practice. Moreover, since many mothers experience breastfeeding
526 difficulties and most mothers go on to both breastfeed and formula feed, many may find
527 themselves negotiating both breastfeeding *and* formula feeding-related stigmatization, which
528 may lead to feelings of shame, distress, and social isolation (Thomson et al., 2015).
529 Additional in-depth longitudinal research on the multiple forms and effects of stigmatization
530 in the moral experience of infant feeding among diverse groups of women are needed to
531 illuminate these complexities and to help establish a culturally supportive environment for
532 breastfeeding without marginalizing those who do not breastfeed. Social scientists who study
533 breastfeeding practice can play a crucial role in providing insight into the cultural aspects of

534 breastfeeding and into concrete strategies for improving policies and health professional-

535 patient communication about these issues.

536

537

ACCEPTED MANUSCRIPT

538 **References:**

539

540 Akre, J.E., Gribble, K.D., & Minchin, M. (2011). Milk sharing: from private practice to
541 public pursuit. *International Breastfeeding Journal*, 6, 1.

542 American Academy of Pediatrics Task Force on Sudden Infant Death Syndrome (2011).

543 SIDS and other sleep-related infant deaths: expansion of recommendations for a safe
544 infant sleeping environment. *Pediatrics*, 128, e1341-e1367.

545 Apple, R.D. (1987). *Mothers and medicine: a social history of infant feeding, 1890-1950*.
546 Madison, Wis.: University of Wisconsin Press.

547 Ball, H.L., & Volpe, L.E. (2013). SIDS risk reduction and infant sleep location: moving the
548 discussion forward. *Social science & medicine*, 79, 84-91.

549 Berry, N.J., & Gribble, K.D. (2008). Breast is no longer best: promoting normal infant
550 feeding. *Maternal & Child Nutrition*, 4, 74-79.

551 Blair, P.S., Heron, J., & Fleming, P.J. (2010). Relationship between bed sharing and
552 breastfeeding: longitudinal, population-based analysis. *Pediatrics*, 126, e1119.

553 Boyer, K. (2011). "The way to break the taboo is to do the taboo thing" breastfeeding in
554 public and citizen-activism in the UK. *Health & place*, 17, 430-437.

555 Boyer, K. (2012). Affect, corporeality and the limits of belonging: breastfeeding in public in
556 the contemporary UK. *Health & place*, 18, 552-560.

557 Buckley, K.M. (2001). Long-term breastfeeding: nourishment or nurturance? *Journal of*
558 *Human Lactation*, 17, 304-312.

559 Cartagena, D.C., Ameringer, S.W., McGrath, J., Jallo, N., Masho, S.W., & Myers, B.J.

560 (2014). Factors contributing to infant overfeeding with Hispanic mothers. *Journal of*
561 *Obstetric, Gynecologic, & Neonatal Nursing*, 43, 139-159.

562 Carter, P. (1995). *Feminism, breasts and breast-feeding*. New York: St. Martin's Press.

- 563 Carter, S.K., Reyes-Foster, B., & Rogers, T.L. (2015). Liquid gold or Russian roulette? Risk
564 and human milk sharing in the US news media. *Health, Risk & Society*, 17, 30-45.
- 565 Cassidy, T.M. (2012). Making “Milky Matches”: Globalization, Maternal Trust and
566 “Lactivist” Online Networking. *Journal of the Motherhood Initiative for Research
567 and Community Involvement*, 3, 226-240.
- 568 Cassidy, T.M., & El-Tom, A. (2010). Comparing sharing and banking milk: issues of gift
569 exchange. In A. Bartlett, & R. Shaw (Eds.), *Giving breastmilk: body ethics and
570 contemporary breastfeeding practices* pp. 110-121). Toronto: Demeter Press.
- 571 Centers for Disease Control and Prevention. (2016). Breastfeeding among U.S. Children
572 Born 2002–2013, CDC National Immunization Surveys. Centers for Disease Control
573 and Prevention.
- 574 Colen, C.G., & Ramey, D.M. (2014). Is breast truly best? Estimating the effects of
575 breastfeeding on long-term child health and wellbeing in the United States using
576 sibling comparisons. *Soc Sci Med*, 109, 55-65.
- 577 Department of Health and Human Services. (2010). Healthy People 2020, Maternal, Infant,
578 and Child Health. Washington, D.C.: Department of Health and Human Services,
579 Office of Disease Prevention and Health Promotion.
- 580 Douglas, M. (1966). Purity and danger: An analysis of the concepts of pollution and taboo.
581 *Pantheon, New York*.
- 582 Dowling, S. (2011). Online asynchronous and face-to-face interviewing: Comparing methods
583 for exploring women’s experiences of breastfeeding long-term. In J. Salmon (Ed.),
584 *Cases in online interview research* pp. 277-296). Thousand Oaks, CA; London, U.K.;
585 New Delhi, India: Sage Publications.

- 586 Dowling, S., & Brown, A. (2013). An exploration of the experiences of mothers who
587 breastfeed long-term: what are the issues and why does it matter? *Breastfeeding*
588 *Medicine*, 8, 45-52.
- 589 Dowling, S., & Pontin, D. (2015). Using liminality to understand mothers' experiences of
590 long-term breastfeeding: 'Betwixt and between', and 'matter out of place'. *Health*.
- 591 Dykes, F. (2006). *Breastfeeding in hospital: mothers, midwives and the production line*.
592 Oxon: Routledge.
- 593 Faircloth, C. (2010a). 'If they want to risk the health and well-being of their child, that's up to
594 them': Long-term breastfeeding, risk and maternal identity. *Health, Risk & Society*,
595 12, 357-367.
- 596 Faircloth, C. (2010b). 'What Science Says is Best': Parenting Practices, Scientific Authority
597 and Maternal Identity. *Sociological Research Online*, 15, 4.
- 598 Faircloth, C. (2011). 'It feels right in my heart': affective accountability in narratives of
599 attachment. *The Sociological review*, 59, 283-302.
- 600 Faircloth, C. (2013). *Militant lactivism?: attachment parenting and intensive motherhood in*
601 *the UK and France*: Berghahn Books.
- 602 Faircloth, C. (2015). Breastfeeding doesn't determine a child's future, so we should stop
603 pretending like it does. The Independent. London, UK.
- 604 Fildes, V.A. (1988). *Wet nursing: a history from antiquity to the present*: Basil Blackwell
605 Oxford.
- 606 Fischer, T.P., & Olson, B.H. (2014). A qualitative study to understand cultural factors
607 affecting a mother's decision to breast or formula feed. *Journal of Human Lactation*,
608 30, 209-216.
- 609 Geraghty, S.R., Heier, J.E., & Rasmussen, K.M. (2011). Got milk? Sharing human milk via
610 the Internet. *Public Health Reports*, 161-164.

- 611 Goffman, E. ([1963] 1986). *Stigma: Notes on the management of spoiled identity*. New York:
612 Touchstone.
- 613 Grant, A. (2016). “# discrimination” The Online Response to a Case of a Breastfeeding
614 Mother Being Ejected from a UK Retail Premises. *Journal of Human Lactation*, 32,
615 141-151.
- 616 Gribble, K.D. (2008). Long-term breastfeeding; changing attitudes and overcoming
617 challenges. *Breastfeeding Review*, 16, 5-15.
- 618 Gribble, K.D. (2014a). 'A better alternative': Why women use peer-to-peer shared milk.
619 *Breastfeeding Review*, 22, 11.
- 620 Gribble, K.D. (2014b). Perception and management of risk in Internet-based peer-to-peer
621 milk-sharing. *Early Child Development and Care*, 184, 84-98.
- 622 Gribble, K.D., & Hausman, B.L. (2012). Milk sharing and formula feeding: Infant feeding
623 risks in comparative perspective? *The Australasian medical journal*, 5, 275.
- 624 Griffiths, L.J., & Tate, A.R. (2007). Do early infant feeding practices vary by maternal ethnic
625 group? *Public health nutrition*, 10, 957-964.
- 626 Hausman, B.L. (2003). *Mother's milk: breastfeeding controversies in American culture*. New
627 York: Routledge.
- 628 Hausman, B.L. (2007). Things (Not) to Do with Breasts in Public: Maternal Embodiment and
629 the Biocultural Politics of Infant Feeding. *New Literary History*, 38, 479-504.
- 630 Hausman, B.L. (2011). *Viral mothers: breastfeeding in the age of HIV/AIDS*. Ann Arbor, MI:
631 University of Michigan Press.
- 632 Hausman, B.L., Smith, P.H., & Lobbok, M.H. (2012). Introduction: breastfeeding constraints
633 and realities. In P.H. Smith, B. Hausman, & M.H. Lobbok (Eds.), *Beyond health,
634 beyond choice: breastfeeding constraints and realities* pp. 1-11). New Brunswick, NJ:
635 Rutgers University Press.

- 636 Healthtalkonline. (2011). Breastfeeding an older baby Healthtalkonline.
- 637 Hewlett, B.S., & Winn, S. (2014). Allomaternal nursing in humans. *Current Anthropology*,
638 55, 200-229.
- 639 Jung, C. (2015). *Lactivism: How Feminists and Fundamentalists, Hippies and Yuppies, and*
640 *Physicians and Politicians Made Breastfeeding Big Business and Bad Policy*. New
641 York: Basic Books.
- 642 Kleinman, A. (1997). *Writing at the margin: discourse between anthropology and medicine*.
643 Berkeley, CA: Univ of California Pr.
- 644 Kleinman, A., & Hall-Clifford, R. (2009). Stigma: a social, cultural and moral process.
645 *Journal of epidemiology and community health*, 63, 418.
- 646 LeCompte, M.D., & Schensul, J.J. (1999). *Designing and conducting ethnographic research:*
647 Rowman Altamira.
- 648 Lee, E. (2007). Health, morality, and infant feeding: British mothers' experiences of formula
649 milk use in the early weeks. *Sociology of health & illness*, 29, 1075-1090.
- 650 Lee, E. (2008). Living with risk in the age of 'intensive motherhood': Maternal identity and
651 infant feeding. *Health, Risk & Society*, 10, 467-477.
- 652 Lee, E. (2011). Feeding babies and the problems of policy: Center for Parenting Culture
653 Studies briefing March 2011.
- 654 McAndrew, F., Thompson, J., Fellows, L., Large, A., Speed, M., & Renfrew, M.J. (2012).
655 Infant feeding survey 2010. Leeds: Health and Social Care Information Centre.
- 656 McFadden, A., Mason, F., Baker, J., Begin, F., Dykes, F., Grummer-Strawn, L., et al. (2016).
657 Spotlight on infant formula: coordinated global action needed. *The Lancet*, 387, 413-
658 415.
- 659 McKenna, J.J., & Gettler, L.T. (2016). There is no such thing as infant sleep, there is no such
660 thing as breastfeeding, there is only breastsleeping. *Acta Paediatr*, 105, 17-21.

- 661 McKenna, J.J., & McDade, T. (2005). Why babies should never sleep alone: a review of the
662 co-sleeping controversy in relation to SIDS, bedsharing and breast feeding. *Paediatric*
663 *respiratory reviews*, 6, 134-152.
- 664 Mitchell-Box, K., & Braun, K.L. (2012). Fathers' thoughts on breastfeeding and implications
665 for a theory-based intervention. *Journal of Obstetric, Gynecologic, & Neonatal*
666 *Nursing*, 41, E41-E50.
- 667 Morrison, L., Reza, A., Cardines, K.i., Foutch-Chew, K., & Severance, C. (2008).
668 Determinants of infant-feeding choice among young women in Hilo, Hawaii. *Health*
669 *care for women international*, 29, 807-825.
- 670 Mulready-Ward, C., & Hackett, M. (2014). Perception and Attitudes Breastfeeding in Public
671 in New York City. *Journal of Human Lactation*, 30, 195-200.
- 672 Murphy, E. (1999). 'Breast is best': Infant feeding decisions and maternal deviance. *Sociology*
673 *of Health and Illness*, 21, 187-208.
- 674 Murphy, E. (2000). Risk, Responsibility, and Rhetoric in Infant Feeding. *Journal Of*
675 *Contemporary Ethnography*, 29, 291-325.
- 676 Oakley, L.L., Renfrew, M.J., Kurinczuk, J.J., & Quigley, M.A. (2013). Factors associated
677 with breastfeeding in England: an analysis by primary care trust. *BMJ open*, 3,
678 e002765.
- 679 Oster, E. (2015). Everybody calm down about breastfeeding. Fivethirtyeight.com:
680 Fivethirtyeight.com.
- 681 Palmquist, A.E., & Doehler, K. (2014). Contextualizing online human milk sharing:
682 Structural factors and lactation disparity among middle income women in the US.
683 *Social science & medicine*, 122, 140-147.
- 684 Palmquist, A.E., & Doehler, K. (2015). Human milk sharing practices in the US. *Maternal &*
685 *Child Nutrition*.

- 686 Pfeiffer, J., & Nichter, M. (2008). What can critical medical anthropology contribute to
687 global health? *Medical anthropology quarterly*, 22, 410-415.
- 688 Public Health England. (2014). Children and Young People's Health Benchmarking Tool.
689 National Child and Maternal Health Intelligence Network.
- 690 Public Health England. (2015). New mothers are anxious about breastfeeding in public.
691 Public Health England.
- 692 Public Health England. (2016). Breastfeeding at 6 to 8 weeks after birth: 2015 to 2016
693 quarterly data. Public Health England.
- 694 Rempel, L.A. (2004). Factors influencing the breastfeeding decisions of long-term
695 breastfeeders. *Journal of Human Lactation*, 20, 306-318.
- 696 Rollins, N.C., Bhandari, N., Hajeebhoy, N., Horton, S., Lutter, C.K., Martines, J.C., et al.
697 (2016). Why invest, and what it will take to improve breastfeeding practices? *The*
698 *Lancet*, 387, 491-504.
- 699 Rosin, H. (2009). The Case Against Breast-Feeding. *Atlantic Monthly*, May.
- 700 Ryan, K., Bissell, P., & Alexander, J. (2010). Moral work in women's narratives of
701 breastfeeding. *Social science & medicine (1982)*, 70, 951-958.
- 702 Shaw, R. (2004a). Performing breastfeeding: embodiment, ethics and the maternal subject.
703 *Feminist Review*, 78, 99-116.
- 704 Shaw, R. (2004b). The virtues of cross-nursing and the'yuk factor. *Australian Feminist*
705 *Studies*, 19, 287-299.
- 706 Smale, M. (2001). The stigmatisation of breastfeeding. In C. Carlisle, T. Mason, C. Watkins,
707 & E. Whitehead (Eds.), *Stigma and Social Exclusion in Healthcare* pp. 234-245).
708 New York, NY: Routledge.
- 709 Stearns, C.A. (2011). Cautionary tales about extended breastfeeding and weaning. *Health*
710 *care for women international*, 32, 538-554.

- 711 Stuebe, A. (2009). The risks of not breastfeeding for mothers and infants. *Rev Obstet*
712 *Gynecol*, 2, 222-231.
- 713 Thomson, G., Ebisch-Burton, K., & Flacking, R. (2015). Shame if you do—shame if you
714 don't: women's experiences of infant feeding. *Maternal & Child Nutrition*, 11, 33-46.
- 715 Thorley, V. (2011). Mothers' experiences of sharing breastfeeding or breastmilk, part 2: the
716 early 21st century. *Nursing Reports*, 2, 2.
- 717 Tomori, C. (2014). *Nighttime breastfeeding: an American cultural dilemma*. New York:
718 Berghahn Books.
- 719 UNICEF. (2015). Baby Friendly statistics 2015 UNICEF.
- 720 United Kingdom Government. (2015). Maternity pay and leave U.K.: United Kingdom
721 Government.
- 722 Van Maanen, J. (2011). *Tales of the field: On writing ethnography*: University of Chicago
723 Press.
- 724 Victora, C.G., Bahl, R., Barros, A.J., França, G.V., Horton, S., Krasevec, J., et al. (2016).
725 Breastfeeding in the 21st century: epidemiology, mechanisms, and lifelong effect. *The*
726 *Lancet*, 387, 475-490.
- 727 Wiessinger, D. (1996). Watch your language. *J Hum Lact*, 12, 1-4.
- 728 Wolf, J.B. (2007). Is Breast Really Best? Risk and Total Motherhood in the National
729 Breastfeeding Awareness Campaign. *Journal of health politics, policy and law*, 32,
730 595-636.
- 731 Wolf, J.B. (2011). *Is breast best?: taking on the breastfeeding experts and the new high*
732 *stakes of motherhood*. New York: New York University Press.
- 733 Wolf, J.H. (2001). *Don't kill your baby: public health and the decline of breastfeeding in the*
734 *nineteenth and twentieth centuries*. Columbus, OH: Ohio State University Press.

- 735 World Health Organization. (1981). International Code of Marketing of Breastmilk
736 Substitutes Geneva, Switzerland: World Health Organization.
- 737 World Health Organization. (2003). Global strategy for infant and young child feeding
738 Geneva, Switzerland: World Health Organization.
- 739 Yang, L.H., Kleinman, A., Link, B.G., Phelan, J.C., Lee, S., & Good, B. (2007). Culture and
740 stigma: adding moral experience to stigma theory. *Social science & medicine*, 64,
741 1524-1535.
- 742
- 743

Acknowledgements

AP's study was supported by a Wenner-Gren Post PhD grant and an Elon University Faculty Research and Development grant. CT's research was supported by the Alfred P. Sloan Foundation; the Ruth L. Kirschstein National Research Service Award Training Grant from the Eunice Kennedy Shriver National Institute of Child Health and Development (T32 HD007339 & T32 HD007339-23) awarded by the Population Studies Center of the Institute for Social Research, University of Michigan; and the Rackham Graduate School, the Department of Anthropology, and the Center for the Education of Women at the University of Michigan. SD's study was supported by a PhD Studentship from the Faculty of Health and Applied Sciences, University of the West of England, Bristol. The funding sources had no involvement in the design, data collection, analysis, or interpretation of the research, or the publication process. We are deeply grateful to our study participants for making our research possible.

Research Highlights

- Investigates the moral experience of breastfeeding in the U.S. and the U.K.
- Analyzes ethnographies of breastmilk sharing, nighttime and long-term breastfeeding
- Illustrates mothers' use of stigma management techniques to avoid moral judgment
- Breastfeeding is becoming a cultural ideal but its praxis still evokes moral danger
- Argues for ethnographic research to inform breastfeeding policies and initiatives