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

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Abstract

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

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

Key Words

United States; United Kingdom; breastfeeding; stigma; breastmilk sharing; nighttime breastfeeding; bedsharing; long-term breastfeeding

Introduction

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

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

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

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

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

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

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

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

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

Methods

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

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

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

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

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

Results

Breastmilk sharing in the U.S.

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

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

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

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

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

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

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

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

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

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

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

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

Nighttime Breastfeeding in the U.S.

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

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

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

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

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

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

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

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

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

Long-term breastfeeding in the U.K

It is unusual in the U.K. to see breastfeeding beyond the first six months, and especially after a year. Research on U.K. women's experiences of breastfeeding beyond six 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

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

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

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

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

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

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

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

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

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

Discussion

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

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

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

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

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

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

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

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

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

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

breastfeeding and into concrete strategies for improving policies and health professional-patient communication about these issues.

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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