

INTRODUCTION

When I visited Kate¹ and Joshua at their home for our first meeting a week and a half after their daughter's birth, we had a lot to catch up on. I had met Kate, a schoolteacher, and Joshua, an ecologist, a married couple in their late twenties, at a local childbirth education center several months earlier. Together with a group of other middle-class pregnant women expecting their first child, their partners, and an instructor, we spent two and a half hours together each week during the long Midwestern winter for the seven sessions of the course and the additional sessions of breastfeeding and infant care courses. This couple, like the others I worked with during my research, chose to participate in my study because they intended to breastfeed for at least six months, they were interested in my research, and they wanted to help out a student. Kate and Joshua welcomed me into their lives and approached my research on nighttime breastfeeding—much of which concerned aspects of their lives they rarely shared with others, let alone with a complete stranger—with the same openness and sense of humor that I observed during my initial interactions with them in childbirth education classes. Throughout the year that followed the birth of their daughter, Anna, we would spend many hours together as I learned more about their breastfeeding and sleep experiences and how these experiences fit into the fabric of their everyday lives.

During this particular meeting, Kate and Joshua were thrilled to introduce me to their new daughter. Amidst carrying, changing, and breastfeeding Anna, they shared their experiences with labor and childbirth at one of the local hospitals. I learned that although they did manage to achieve their goal of not using anesthetics during their daughter's birth, they nevertheless experienced several unwanted medical interventions. I also learned that, despite their extensive preparations, breastfeeding and infant sleep had both presented un-

anticipated challenges. Kate's breasts became extremely sore, raw, and "scabby" shortly after they returned to their home. Thanks to help from the visiting nurse on how to position the baby during breastfeeding and from an ointment prescribed by their nurse-midwife, breastfeeding was going much better in the few days prior to our meeting. Still, the soreness was returning as Kate was learning to breastfeed while lying down—a skill that she found challenging, although far less tiring and more comfortable than breastfeeding while seated and propped up with pillows. In the haze of exhaustion from the trials of the lengthy birth process compounded by breastfeeding difficulties, Kate and Joshua also found that Anna "did not want to" sleep when put down on her back in the three-sided bassinet, called a Co-Sleeper, that attached to their bed. When they tried putting her in the Co-Sleeper, Anna woke up after five minutes, and continued to do so each time they tried again. Thus, Kate and Joshua spent the night alternating between long breastfeeding sessions and sleeping for an hour or two with Anna sleeping on one of their chests.

Although sleeping with their daughter in this way allowed Kate and Joshua to get some much-needed rest and to breastfeed her with relative ease, this arrangement raised several concerns. Kate worried about the safety of falling asleep with Anna on her chest and the potential of not being aware of her location in relation to her and the bed. In turn, Joshua was concerned that Anna would learn only to sleep on a parent and therefore would not be able to sleep without being on a parent's body. In response to these concerns, Kate and Joshua developed a new way of sleeping, building on Kate's recent discovery that after breastfeeding her while lying down in bed, both she and Anna could stay asleep for two to three hours at a time. Using words and gestures, Kate described how the three of them now slept in the same bed, with Anna laying on her side at Kate's breast level, her body encircled by Kate's arm from above and her knees pulled up from below. Joshua continued to take Anna and sleep with her on his chest when she did not stay asleep after breastfeeding. While this discovery ultimately facilitated both their breastfeeding plans and sleep for Kate, Joshua, and Anna, it would take considerably more negotiations, assistance, and effort to comfortably settle into their nighttime feeding and sleep arrangements.

For Kate and Joshua, as well as many other couples in my study, the problematic status of breastfeeding infants sharing their parents' bed in the United States presented a major obstacle to attaining a

sense of ease about their nighttime practices. Initially motivated by their desire to follow medical recommendations for the best way of feeding babies, many of the couples in my study suddenly found themselves at odds with medical advice about safe sleep, which prompted questions about endangering or even killing their child. Moreover, bringing their babies into bed and continuing to breast-feed them over the course of the year raised additional concerns about the implications of their nighttime practices for their children as well as for themselves. Would these practices cause their baby to be unable to sleep on her own in the future and fail to become an independent and self-reliant person? Would nighttime bed sharing and breastfeeding disrupt their marriage or somehow harm their child? Alternately, if they decided not to bring their babies into bed with them, how would they get their children to sleep and how could they manage to sustain nighttime breastfeeding? Couples were also ambivalent about when and how nighttime breastfeeding sessions would give way to continuous blocks of sleep, preferably in a crib in a separate room that they had lovingly prepared as a nursery, often months before their babies' birth. Developing an approach to nighttime breastfeeding and sleep often became a central issue for couples and formed a cornerstone of their parenting practices. Far beyond decisions about nourishment and rest, nighttime breastfeeding and sleep constituted a quandary that each family approached differently.

These dilemmas of nighttime breastfeeding and sleep are the subject of this book. For an anthropologist, such dilemmas highlight an area of tension and ambivalence that, when unraveled through careful research, can shed light on larger cultural concerns. While controversies around infant feeding and sleep decisions abound in the media and have generated scholarly discussions, comparatively little anthropological research exists on how those who plan to breastfeed actually negotiate these embodied processes. Furthermore, aside from the notable efforts of biological anthropologists, sociocultural anthropologists and other qualitative researchers have devoted little attention to nighttime breastfeeding and sleep. Drawing on insights from a longitudinal ethnographic study of middle-class breastfeeding families in a Midwestern U.S. city, my book addresses this scholarly lacuna. The volume explores how the quandaries of nighttime breastfeeding and sleep can provide insight into cultural expectations for babies and their relationship with parents, concepts of health and medical authority, and unequal sociocultural, political, and economic social relations that are the hallmarks of late capitalist America.

The Cultural Problem of Nighttime Breastfeeding and Sleep in the U.S.

The couples in my study embarked on their breastfeeding journey at a time when the U.S. and similar wealthy industrial nations have witnessed a resurgence of breastfeeding due mainly to international and government-led health initiatives that promote breastfeeding in an effort to improve maternal and child health and reduce health care costs.² Although these efforts have led to a sharp rise in breastfeeding shortly after birth, significantly fewer mothers follow medical recommendations of exclusive breastfeeding for six months and continuing to breastfeed while supplementing with other foods for at least one year. Nevertheless, these rates represent a slow but steady increase. In 2011, the year for which the latest data are available in the United States, 76.5 percent of women began breastfeeding, a rate that dropped to 49 percent by six months (and a much lower rate of 16.4 percent for exclusive breastfeeding) and then to 27 percent by one year postpartum (CDC 2013a). Despite significant progress over the last decade, aggregate breastfeeding rates conceal considerable racial, ethnic and class differences among women (CDC 2013b, 2010c). The U.S. stands out among wealthy industrial nations for its resistance to implementing structural changes that support breastfeeding, such as access to health care, paid parental leave, subsidized and on-site childcare, and tighter regulation of the infant formula industry.³ These discrepancies put parents in a paradoxical position where they must make infant feeding decisions in a climate that valorizes breastfeeding but does little to facilitate it.

Indeed, a growing body of scholarly literature criticizes breastfeeding advocacy for characterizing breastfeeding as a matter of individual responsibility and a morally superior form of infant feeding.⁴ Feminist scholars and journalists have been particularly vocal in articulating their objections to the patriarchal implications of such a strategy and have expressed serious concern about breastfeeding promotion based solely on the biomedical properties of breastmilk.⁵ Some critics, such as women's studies scholar Joan Wolf (2011), have questioned the scientific basis of breastfeeding advocacy and argued that such efforts have established a climate where breastfeeding is a moral imperative, ultimately contributing to an ideology of "total motherhood" that is characterized by a single-minded focus on minimizing risks for children while subsuming women's agency in this familial labor.

Yet media controversies surrounding breastfeeding reveal a much more complex cultural terrain wherein breastfeeding continues to

elicit considerable anxiety.⁶ Breastfeeding mothers are routinely asked to leave restaurants, art museums, airplanes, and other public spaces because of concerns over others' exposure to their nude breasts and the sight of children nursing at the breast, which is viewed as sexual.⁷ Reports of breastfeeding children beyond one year generate concern about the mother's inappropriate, potentially incestuous, relations with her child.⁸ Even breastmilk, the substance that ostensibly possesses precious biological qualities, generates suspicion and disgust—for instance, when breastmilk is expressed in the workplace and put in a communal refrigerator.⁹ Moreover, breastfeeding and breastmilk are also considered potential threats to health. Breastfeeding has been portrayed as inadequate or insufficient, causing malnutrition, disease (e.g., rickets), starvation, and even death.¹⁰ Breastmilk is considered a conduit for dangerous pharmaceuticals, illegal drugs, alcohol, environmental toxins, and potentially lethal infections, including HIV and the West Nile virus.¹¹ Thus, the moral status of breastfeeding is a complicated matter that warrants greater attention.

Many of these concerns were recently captured by reactions to the May 2012 *Time* magazine cover featuring a woman breastfeeding her three-year-old son. In the photo the white, blond, thin, and attractive mother, dressed in skinny jeans and a dark blue camisole, stands with one hand on her hip, looking straight into the camera, as she breastfeeds her son. Her son, wearing camouflage pants and a grey long-sleeved shirt, stands on a small chair and looks tentatively at the viewer as he breastfeeds from his mother's exposed breast. Below the woman's elbow, the caption reads "ARE YOU MOM ENOUGH?" with the latter two words highlighted in bold red lettering, and below, in smaller letters: "Why attachment parenting¹² drives some mothers to extremes—and how Dr. Bill Sears became their guru." Co-sleeping, which in colloquial language refers to sharing a bed with one's child,¹³ was mentioned in the *Time* magazine article along with breastfeeding beyond one year in the list of unusual and "extreme" behaviors espoused by those following the attachment parenting philosophy, which is ostensibly "more about parental devotion and sacrifice than about raising self-sufficient kids" (Pickert 2012).

The photo selected for the cover produced a firestorm of reactions, the majority of them condemning breastfeeding a child at such an advanced age. A large number of comments on various sites that discussed the controversial cover reacted with visceral disgust, with comments suggesting that the mother was breastfeeding the child for her own (sexual) pleasure and was harming the child. Some

suggested that it was time for the mother to let her husband take a turn at her breast. As others have pointed out, the cover was likely set up to draw this kind of reaction, since it highlighted the mother's gender and sexuality through her dress, pose, and exposed breast and accentuated the size of the child through the use of the chair on which he stood, as well as his masculinity through wearing camouflage pants.¹⁴ Indeed, breastfeeding mothers are highly unlikely to adopt such a bodily pose for breastfeeding. The cover was designed to incite controversy by positioning women who breastfeed their children past one year as "extreme" with the subtext of incest lurking barely below the surface.¹⁵

By addressing the discomfort surrounding breastfeeding in the context of nighttime sleep arrangements, my study provides a unique window into this and similar other controversies. While bed sharing with infants is commonly practiced and accepted in many areas of the world, in the U.S. bed sharing magnifies cultural fears associated with breastfeeding and is presumed to hinder children's independence, disrupt parental sexual relations, interrupt parents' sleep, and even provoke incest. Consequently, as in the *Time* magazine article, bed sharing is often portrayed as "extreme." Yet, there is considerable cultural variation in the perception and practice of bed sharing even within the U.S.¹⁶ Moreover, there are growing indications that, like Kate and Joshua, breastfeeding parents frequently bring their babies into their beds at night to ease breastfeeding and enhance both mothers' and babies' sleep.¹⁷ Biological anthropological and biomedical research indicates that nighttime breastfeeding with proximal sleep arrangements mutually support the physiology of breastfeeding and human infant sleep.¹⁸ Although this form of co-sleeping has not returned in step with rising breastfeeding rates, the recent National Infant Sleep Position Study has revealed that between 1993 and 2000 the portion of infants who slept with their mothers for all or part of the night doubled, reaching nearly 50 percent (Willinger et al. 2003). Experts attribute this increase at least in part to rising breastfeeding rates.¹⁹

Mainstream medical advice reinforces fears about bed sharing with added concerns about the increased risk of Sudden Infant Death Syndrome (SIDS) in early infancy²⁰ and the necessity of lengthy, uninterrupted sleep for optimal health for both children and adults.²¹ Due to the stigma attached to bed-sharing, breastfeeding parents are left without guidance on how to sleep safely near their children and often conceal their bed-sharing practices. Only a small group of experts advocate a different approach that would support breast-

feeding parents and provide evidence-based guidance that attends to the specific context of infant sleep arrangements.²² Parental concern over how to approach nighttime breastfeeding and infant sleep is evidenced by the enormous amount of discussion of these issues on internet parenting sites, in news media, and in childcare books and magazines. As more parents attempt to breastfeed, more are also likely to confront cultural prohibitions and contradictory mainstream medical advice, intensifying debates about breastfeeding and sleep.

In *Nighttime Breastfeeding*, I show that such debates comprise a part of the challenges and tensions that arise from the global trend toward increasing medicalization or, more specifically, biomedicalization²³ of the body and of reproduction, in particular.²⁴ As the body has come under intense medical scrutiny, experts have become medical and moral authorities on every aspect of producing children.²⁵ Furthermore, in U.S. society, bodily processes are increasingly considered domains of health, wherein risk of illness and death can be monitored and managed.²⁶ Much of the expert attention is focused on maternal bodies and behavior that are seen as particularly important in shaping the health of children and ultimately the nation.²⁷ Scholars have documented that mothers themselves have actively participated and continue to participate in bringing about, resisting, internalizing, and negotiating medical authority, their positions shaped by their own sociocultural and economic position.

Moreover, the heated debates that surround topics we now consider health issues, including breastfeeding and infant sleep, reflect the specific structural challenges, complex social relations, and moral debates in which these bodily processes are embroiled. Drawing on in-depth ethnographic research, my book reveals that these reproductive processes are not only central to ever-expanding regimes of health, but also are at the heart of key cultural concerns about what it means to be a mother, partner, child, and family; what really matters in the relationships between parents and children; and how these relationships participate in far-reaching political economic webs that reproduce inequalities.

The Ethnographic Study

This research arose from my findings in a previous pilot project that I undertook in 2003²⁸ to learn about the experiences of breastfeeding in Green City, a small Midwestern city that I will describe in greater detail below. In that pilot study of breastfeeding mothers,

participants repeatedly returned to the topic of sleep in relation to their breastfeeding practices, which prompted me to design a larger ethnographic study to investigate these issues in greater depth. Although my research had a strong focus on nighttime breastfeeding, I aimed to situate my findings in this area within the larger context of breastfeeding. Thus, while my nighttime emphasis is apparent throughout the book, several chapters have a broader focus.

In contrast to public health studies that have focused on the barriers to breastfeeding in poor communities and among racial and ethnic minorities with low rates of breastfeeding, I chose to explore how middle-class families negotiate these experiences. The attention to middle-class families served multiple purposes. First, middle-class families provided a sample that would possess the resources necessary to breastfeed in accordance with medical recommendations, enabling me to observe how breastfeeding is incorporated into the experiences of everyday lives and relationships over a sustained period of time.²⁹ I had hoped, and indeed found, that this length of time would also enable me to develop closer relationships with participants, which would yield deeper insights into how they negotiated sleep in relation to breastfeeding, especially in light of the controversies that surround infant sleep practices that might make participants reluctant to discuss these arrangements. Second, I wanted to examine elements of social class that otherwise might be left unexplored in relation to breastfeeding, such as how these families mobilize their resources and divide labor in order to breastfeed and how these negotiations figure into the makings of social class as well as gender. Making these processes more visible would shed light on the subtle privileges middle-class parents might take for granted, thereby exposing the larger inequalities of which disparities in breastfeeding rates are a part. Finally, I sought to explore middle-class families as trendsetters.³⁰ My research into the history of childbirth in the U.S. has taught me (see chapter 2) that wealthier families played an important role in inviting physicians into the domain of childbirth, a transition that eventually transformed childbearing for all women in the U.S.³¹ In a similar fashion, families' negotiations of the conflicting medical approaches to breastfeeding and sleep would potentially have implications for many others.³²

Research in Green City

Green City is a city of approximately 110,000 people located within commuting distance of a large Midwestern city that was a major center of the auto industry as well as other industry earlier in the

twentieth century but that has since gone into significant economic decline. According to the 2000 census, the population of Green City was three-quarters white, about 12 percent Asian, and 9 percent African American, with a median household income of approximately \$46,000³³ (U. S. Census Bureau 2000). Green City and its immediate vicinity is home to many higher educational institutions, including two large public universities, a large community college, as well as some smaller private institutions, and its population is highly educated.³⁴

Green City was well suited to examine the relationship of breastfeeding and sleep arrangements because of its comparatively high breastfeeding rates,³⁵ the presence of a large community of alternative birthing practitioners and supporters, and a significant number of breastfeeding support organizations, some of which support co-sleeping. Green City had two large health systems—a university-affiliated system and a private system with approximately 4,000 annual births each. Green City was known locally as well as throughout the state for its resources in childbearing that cater to different philosophies of childbirth and approaches to breastfeeding and parenting. Both hospitals had affiliated certified nurse-midwifery practices in addition to the traditional obstetrics/gynecology practices. Furthermore, Green City had a strong community of home birth midwives. This is particularly notable, since home births are extremely rare in the United States, composing only approximately 0.6 percent of all births (MacDorman, Menacker, and Declercq 2010). Previous research indicated that those participating in alternative birth practices might also consider co-sleeping with their babies, contributing to a diverse sample of sleep practices in the study.³⁶

To complement these local resources, families could attend several different childbirth education courses that were reimbursed by major insurers, choose from a large selection of trained professional birth support personnel (doulas) who assisted both low- and higher-income populations, hire pregnancy massage providers and lactation consultants, and shop in stores that supply a variety of goods relating to childbearing as well as other related services. Finally, in addition to hospital-based lactation consultant programs, Green City possessed a large chapter of La Leche League International (LLLI), an international non-profit breastfeeding support organization. During the period of my research, five local LLLI groups met on a regular basis in various locations across the city. My previous research revealed that in addition to Green City residents, parents from surrounding areas frequently utilized these groups. Since LLLI supports

co-sleeping as an approach for accommodating infants' frequent need to breastfeed at night,³⁷ this resource is often considered helpful to those exploring alternative sleep arrangements that differ from mainstream recommendations. The wealth of these services reflected the presence of educated middle-class consumers in the area who were adequately covered by health insurance and could locate and purchase additional resources that they perceived to be necessary.

In sum, Green City was ideally suited for investigating parental practices such as long-term breastfeeding³⁸ and a variety of sleep arrangements that are relatively less common in the greater U.S. population, as well as for learning how middle-class parents incorporate these practices into their lives. Green City provided the center of the majority of my fieldwork activities, as it was the center for childbirth education resources, hospitals, and work for most of my participants. Following my participants also took me out of Green City to neighboring areas, primarily to Neighbor City, where three participating families—including Kate and Joshua—lived, and to three other communities that were located closer to the larger metropolis I described above. Nevertheless, families in Neighbor City had substantial work and educational ties to Green City, and the three latter families regularly relied on various Green City services, particularly in the realm of health care. In subsequent chapters I provide more detailed information on how these families were connected to Green City through childbirth education services, and I discuss details of the neighborhoods and communities in which my study participants resided.

Ethnographic Fieldwork

A key question in pursuing this research was how to gain knowledge about practices that occurred during the night, in participants' bedrooms. Biological anthropologists have employed laboratory research that included videotaping mothers and infants sleeping together and apart as well as the collection of physiological data during these periods.³⁹ These researchers have also conducted videotaping in hospitals and families' homes, complemented by survey questionnaires and interviews. As a sociocultural anthropologist, many of these techniques were neither possible nor necessarily desirable for developing a better sense of the sociocultural context in which nighttime breastfeeding and sleep arrangements were practiced. Other ethnographers, such as Alma Gottlieb (2005), learned about nighttime practices by living in the same community with their participants and overhearing and witnessing how they dealt with

nighttime awakenings, and later discussed these arrangements in greater depth during the daytime.

Similar to the majority of my participants, I lived in Green City with my own family, but due to far less proximal housing arrangements and differences in the social practices of sleep, I could not interact with participants during the night. One option would have been to live with a specific family or alternate living arrangements among families. This option was not feasible due to my own family commitments. While this approach would have offered certain advantages, it would have also limited my ability to gather ethnographic data about a larger group of families over a longer period of time. By selecting childbirth education courses as the focal points for my recruitment, I was able to simultaneously situate my study in important local sites where groups of expectant parents gather while also entering into long-term participant-observer relationships with my core group of participants. Although these study methods prevented me from physically sharing the experiences of nighttime, the richness of interactions during the remainder of the day nevertheless enabled me to gather unique insights into the night. I complement my ethnography with research from biological anthropological studies in order to compensate for my lack of physical observations of nighttime interactions.

Fieldwork relationships were foundational to my ability to learn about breastfeeding and sleep practices, especially in light of fears of negative judgment about controversial sleep practices and various challenges to breastfeeding. I learned that it was primarily during the day that participants reflected on their nighttime experiences, discussed them with their spouses, and devised various plans for what they were going to do. These activities were not simply prompted by my presence or questions, although this additional sharpening of reflection was certainly a part of our interactions. But more often, participants reported their reflections along the way and their conversations with others that shaped their own understanding. This kind of reflexivity is itself a characteristic of middle-class conduct and is shaped by my participants' educational experiences, wherein reflexivity is encouraged, as well as by middle-class self-help literature and therapeutic discourses. Although I paid close attention to the conversations I had with my participants, I also devoted considerable time to learning about other aspects of their practice, including where and how participants slept and fed their children, how they conducted themselves in our interactions, and the material cultural practices in which they engaged.

Upon gaining Institutional Review Board approval, I conducted two years of fieldwork between 2006 and 2008, with brief follow-up work at a one of the local hospitals (“University Hospital”) in 2009. During the fieldwork period, I attended courses at two large childbirth education centers that also served as my recruitment sites for core participants. I centered my study on pregnant women who were becoming first-time mothers⁴⁰ and who planned to breastfeed six months or more, their partners, and later their children. My focus on first-time mothers enabled me to document women’s first bodily encounters with the practice of breastfeeding. Depending on the timing of these courses during their pregnancy, I followed participants from the second or third trimesters through at least the end of their child’s first year of life. Since breastfeeding mothers constituted my primary participants, I met with them much more regularly than with spouses. Spouses participated in different ways. Some were able to and wanted to be part of our meetings on a regular basis, while others could not do so or were not as interested in setting up more regular meetings. I always met participants at their level of interest, staying attuned to their wishes. Consequently, I spent considerable time with some spouses, while I met others less frequently, during their lunch break or at a weekend or evening meeting.

During the fieldwork period, I undertook extensive participant observation, supplemented by additional methods described below. Participant observation was based primarily in the participants’ homes, although some meetings took place at local cafes and restaurants, at workplaces, as well as in participants’ neighborhoods. Participant observation included spending time with and participating in activities with the family. During these occasions we shared food and conversation, and participants attended to their regular activities. Much of this time included participants caring for their children, including breastfeeding, bottle-feeding, feeding of other foods (later), diapering, changing, burping, bathing, playing, and soothing (among others). I went for walks, held babies, washed dishes, and otherwise tried to be a helpful participant in these daily activities.

In order to make sure that I kept track of participants regularly over the course of the year, I conducted semi-structured interviews loosely scheduled around the targets of within a few weeks of birth and at three months, six months, nine months, and twelve months. Nearly all of these interviews were audiotaped.⁴¹ However, I remained flexible in order to honor personal needs for recovery from childbirth as well as the vicissitudes of everyday life—primarily sick-

ness, conflicting schedules, and work demands. I tried my best to impose as little as possible on participants' lives so that they did not feel like our meetings were yet another chore amidst the many others engendered by caring for small children, work, family obligations, and other demands.

During our first meeting, I collected basic sociodemographic data and elicited information about participants' plans for birth, breastfeeding, and sleep arrangements, and their reasons for making these plans. Furthermore, I asked about participants' families, employment practices, and plans for after their babies' birth. In these conversations I cast my net broadly to get a sense of the context of participants' plans. Over the course of later meetings I also elicited information about the experiences of the previous night, assessed present breastfeeding and sleep arrangements, and discussed plans for the future. I incorporated a sleep/feeding log documenting parents' and children's location in the house and any feedings and awakenings during the previous night in some of these discussions, depending on whether participants wished to fill one out (see Appendix 1).⁴² Of the larger group, a smaller group of participants were willing to have more frequent meetings and conversations. These participants tend to feature more in my discussions, although I draw on examples from others and incorporate what I learned from every participant in the main arguments of the book. Within this smaller group, I also carried out some videotaped observations.

Over time I came to know my participants and their families quite well and even interviewed some of their extended family members. During fieldwork I listened to many difficult and heart-breaking experiences and shed tears as well as celebrated joy and laughter together. Many participants have kept in touch with me since the study's conclusion and have sent me their birth announcements for their second child as well as updates about their lives, and several former participants said that they missed our conversations and wished that we would be able to continue our meetings even after many months passed since our last study meeting. In turn, I also found that I grew quite accustomed to meeting with participant families and felt a part of them, albeit to different degrees. Despite this sense of connection, fieldwork remained quite challenging, due to both the pragmatic challenges of juggling visits to many different families at once as well as the work of learning about each person and family and their unique pattern of engagement with me.

Beyond following the core participants, I interviewed and talked informally with local childbirth educators, doulas, midwives, and

lactation consultants, trained as a postpartum doula, observed local hospital childbirth and breastfeeding practices, attended local birth- and breastfeeding-related events, and kept informed of media coverage of childbirth, breastfeeding, and infant sleep issues. In all these ways, I sought to learn as much as I could about the experiences of breastfeeding for the core participants while also situating this knowledge in larger contexts. At the same time, by anchoring the study to the core participants' lives, I hoped to provide a contrasting and complementary perspective to those of medical professionals and public health researchers who may only encounter families for short periods of time, often in the brief and specific context of medical interactions.

A Brief Overview of Core Participants

The core participants of the study were eighteen middle-class first-time mothers, fifteen of their spouses, and their children. An overview of the couples and the characteristics of their births, breastfeeding, and sleep arrangements over the course of the study can be found in the appendixes (see Appendix 2 and 3). Although all spouses were supportive of the study and were happy to talk to me in childbirth education classes as well as in informal interactions during the course of the study, three spouses chose not to formally participate due to their extensive work commitments. Nearly all participants were Euro-American, highly educated, heterosexual married couples and resided in or near Green City. The one same-sex couple in my study married in a ceremony not recognized by the state. All but one couple in my study gave birth at the above two local hospitals and many experienced typical medical interventions for childbirth, with the significant exception that participants used much lower than expected rates of epidural anesthesia (only eight of eighteen mothers received epidural anesthesia, which is given in over 90 percent of births at local hospitals). This result likely reflects the high percentage of couples in the study, and in many of the childbirth education courses I attended throughout my fieldwork, who desired an unmedicated birth and systematically sought out resources in order to pursue this goal.

All expectant mothers planned to breastfeed for six months to a year and all succeeded in doing so.⁴³ All but two of the eighteen mothers continued to twelve months and many beyond. Of these two women, one stopped at eight months due to a serious medical condition that required taking prescription medication with potentially serious side-effects for her baby. The second received pediatric

advice for the cessation of nighttime breastfeeding, which contributed to her stopping breastfeeding by nine months. All but one family brought their babies into their bed during the night at least for short periods of time. Nearly all families practiced more sustained bed sharing over the course of the study, by itself or in combination with other sleep arrangements. At twelve months postpartum, ten couples still practiced partial or complete bed sharing. Compared with the U.S. population, most of these couples were part of the minority who breastfed at one year postpartum, and of an even smaller group who slept in bodily proximity to their children.⁴⁴

Positionality and Fieldwork Interactions

My own position in fieldwork was complex, as is the nature of ethnographic research. In many senses, I build on a long legacy of feminist ethnographers who have studied reproduction in the U.S. after encountering various aspects of reproduction through their own experience.⁴⁵ At the same time, I did not grow up in the U.S. and therefore did not return to examine reproduction there with fresh eyes, nor have I conducted previous ethnographic research elsewhere, as is common in the discipline. My own trajectory originates in Hungary, where I was raised until I entered high school on the East Coast of the U.S., learning English in the course of those years, during which I still spent considerable time in Hungary. By the time I entered fieldwork, however, I had gone to college in the U.S., married a U.S. citizen, birthed, breastfed, and cared for two young children with my husband, and had become a permanent U.S. resident. Throughout this process I had increasingly become not only a Hungarian living in the U.S., but a Hungarian American.

This brief account reflects the growing diversity of persons and life experiences ethnographers bring to anthropology. Unlike in the times of the discipline's origins, women (including mothers) now constitute a significant voice in anthropology, although they continue to face many gender-based barriers, especially as related to their responsibilities of caring for children.⁴⁶ With anthropology's growing incorporation of feminist approaches and reflexive ethnography, women have also increasingly incorporated their experiences of motherhood into their research.⁴⁷ Furthermore, ethnographers also increasingly represent a diversity of sexual, racial, ethnic, class, religious, and geographic histories. This diversity, as well as greater attention to the various ways in which similarity and difference is evoked in social interaction, has prompted anthropologists to question dichotomies between "native" anthropologists who have been

described as studying “their own” culture and other anthropologists, who have followed disciplinary traditions to study “other” cultures.⁴⁸ Following this work as well as that of others who have reflected on the politics and experiences of fieldwork experiences,⁴⁹ I begin with a few reflections about my engagement in the research I undertook.

My own personal history figured into my ethnographic interactions in multiple ways. First, I was already a mother of young children when all the mothers and all but one of the spouses were expecting their first children. Second, I was an anthropologist studying reproduction. These are clearly interlinked domains; my own experiences were foundational for developing my commitment to study breastfeeding as an anthropologist. Furthermore, I was a mother-anthropologist with an explicit position that breastfeeding is an embodied process worth caring about and supporting. While I did not advocate breastfeeding, I was clear in my interactions with participants that I supported breastfeeding. At the same time, my own perspective on breastfeeding is a socially situated one—I was fully aware of the many obstacles to breastfeeding, empathized with participants’ challenges in breastfeeding, their use of formula, and decision to stop to breastfeeding. I took a similar approach to sleep arrangements, again empathizing with the various difficulties participants encountered regardless of where they all slept each night.

The above orientations positioned me as someone who was knowledgeable about an area of life that my participants looked forward to with great anticipation, but to which most had little exposure in their everyday lives. Even those familiar with children through babysitting had not had a great deal of exposure to very young children. There was also a sense in which I was treated as an “expert,” someone who possessed scholarly knowledge that included certain aspects of medicine related to childbirth, breastfeeding, and sleep, as well as embodied experience through having my own children. In this sense, I was probably regarded most similarly to a “breastfeeding expert,” someone knowledgeable and supportive about breastfeeding and related challenges. I was aware of these roles and was careful to position myself as a friendly, supportive observer, rather than an expert. I am aware that these efforts mitigate, but do not erase this element in our interactions. Nevertheless, I did not share my own experiences of motherhood nor my anthropological knowledge without explicitly being asked to do so. Participants did inevitably ask many questions about both these realms of my life (as well as others), and during these occasions I answered honestly but without offering more than what I felt was necessary. Through-

out, I was most careful to be supportive and caring and to avoid judgment. I believe that the results of this careful engagement are reflected in the openness of my participants to share their difficulties, dilemmas, and worries without fearing my disapproval.

Despite the potentially limiting effects of being seen as an expert, my own reproductive history greatly facilitated these field interactions. Most prominently, we shared experiences of having children and breastfeeding them. While my having “succeeded” in breastfeeding could be a source of anxiety for struggling mothers, several participants noted that they felt that knowing such a mother helped them feel more reassured about their ability to breastfeed. My physical comfort with breastfeeding was an important part of enabling my fieldwork. In a cultural climate where breastfeeding in public is shunned, mothers did not have to worry about exposing their breasts during breastfeeding in my presence (as affirmed by the lack of covering during these feedings as well as their comments). Furthermore, many mothers spent their early weeks and months at home, partly due to the difficulty of nursing discreetly in public when just learning how to breastfeed as well as the challenges of bundling up young babies in the cold winter and putting them in and out of car seats for transportation. For these mothers, I was welcome company and conversation partner. Consequently, I spent a great deal of fieldwork with mothers breastfeeding babies right next to me, from the beginning moments when they were just learning how to breastfeed and often struggled to latch on their babies to times when babies became increasingly interested in their surroundings and would happily unlatch in the middle of feeding and smile at me with breastmilk dripping down their cheeks. Such moments are rare in public spaces in the U.S. and would have been impossible to witness without participants’ comfort with me. This sense of closeness was further facilitated by our similarity in race, age, education, and my fluency in English, which did not reveal my foreign roots.

There was a complex gendered element to these interactions. Since my study centered around breastfeeding mothers, I spent most of my time with mothers and shared many aspects of my embodied experiences with them, all of which enhanced our mutual sense of closeness. At the same time, I was cautious not to assume that my own embodied breastfeeding and sleep experiences were the same as those of my participants. While my early breastfeeding experiences with my first son were challenging, leading me to nearly abandon breastfeeding altogether in the first days, I did not encoun-

ter many of the difficulties my participants faced and breastfed both of my sons for several years. My own sleep arrangements were also similarly quickly worked out, with our children co-sleeping in our bed for similar lengths of time. These relatively uncommon practices in the U.S. were supported among my anthropologist colleagues and supervisors, who encountered similar arrangements in their work in other cultural settings. Furthermore, embodied experience always takes place within specific cultural and interpersonal contexts, making even what might appear to be similar experiences to be open to radically different interpretations. I paid close attention to participant accounts in order to avoid misrepresentation based on my own embodied assumptions.

In many regards, I was also a stranger in my participants' world. I grew up in a different culture, speaking a different language, in a different part of the globe that experienced dramatic transformations of the fall of the Soviet-linked socialist regime and the establishment of a new form of democratically elected, capitalist government. Both my native country and my own family within it possessed considerably fewer economic resources than the families in my study. I had children at a much younger age, with far less preparation and fewer financial resources than participants in my study. I approached childbirth and breastfeeding with the same set of expectations I had developed in Hungary, where most women simply went to obstetricians for their care and were told what to do. I did not know about Lamaze classes or any other classes outside hospital courses that physicians recommended nor did I understand why anyone would want to take them. While I assumed that I would breastfeed, as I had heard—although rarely seen—others do in Hungary, I had neither a specific goal for breastfeeding, nor was I aware of the “health benefits” of breastfeeding. At the time of our first son's birth, I did not know what the acronym of SIDS stood for and had never heard of parents sleeping in the same bed with their babies. I acquired more of this knowledge over time, largely through academic study. These experiences distinguished me from my participants and helped to position them in the role of experts as I learned about aspects of middle-class U.S. culture that I had not personally encountered or had only read about in books while taking graduate seminars.

With the passage of time, both men and women participants' perceptions of me shifted from a more expert-stranger positioning toward a kind of kinship brought about by the intensity of my participation in participants' family lives. These kinds of relationships and the appreciation I developed for both differences and similari-

ties between my participants and myself constitute some of the most treasured aspects of fieldwork.

Overview of the Book

The book is divided into seven chapters, followed by a brief conclusion. Each chapter offers a specific set of arguments that draw on a diverse set of literatures in order to illuminate different aspects of my research. These chapters can be seen as bits of mirrored glass that, while they each provide a unique vantage point, when placed together constitute a larger mosaic of one particular perspective on the cultural dilemmas of nighttime breastfeeding and sleep in the United States.

The seven body chapters are loosely organized into four parts. The first part comprises a single chapter that lays the groundwork for my anthropological approach to nighttime breastfeeding. Drawing on a diverse body of sociocultural and medical anthropological scholarship I develop the concept of “embodied moral dilemmas” raised by nighttime breastfeeding as a lens through which we can glean unique insight into the complex dynamics of American personhood, family relations, biomedicine, and the far-reaching effects of capitalism. While I have attempted to make my discussion of the relevant concepts accessible, readers unfamiliar with the discipline of anthropology may find this chapter challenging. These readers may wish to move forward to the next chapters, in which I pursue the above themes through historical and ethnographic examples. I welcome readers to dip back into this chapter based on their interest.

The following two chapters address the role of biomedicine and capitalism in breastfeeding and infant sleep in the U.S. using historical and ethnographic approaches. In chapter 2 I examine struggles over who possesses authoritative knowledge about breastfeeding and sleep to illuminate the complex and contradictory ways in which women and biomedicine are implicated in these processes. I explore the consequences of these complexities for U.S. feminist discussions of breastfeeding and create the framework for the analysis of the dilemmas that participants encounter in their experiences of breastfeeding. The third chapter explores the role of childbirth education courses in mediating biomedical approaches to breastfeeding and infant sleep practices through a comparative ethnographic analysis of two childbirth education sites. I suggest that childbirth education that includes breastfeeding courses is a privileged good that com-

prises a part of middle-class consumption practices, which constitute cultural ideals of parenting. Moreover, I show how the consumption of specific kinds of childbirth education courses provides different frameworks for parents' and children's personhoods and family relationships with one another within the context of a capitalist political economic system. Through their negotiations of biomedical authority in breastfeeding and infant sleep practices, parents engage with these frameworks based on their own histories and experiences.

The fourth and fifth chapters address the gendered negotiation of the dilemmas posed by breastfeeding, keeping nighttime concerns in focus. In the fourth chapter I provide ethnographic insight into middle-class breastfeeding mothers' experiences of the moral contradictions between the simultaneous valuation of the health effects of breastfeeding and the concern over its actual praxis. Mothers' accounts reveal that these contradictions engender modes of stigmatization, which can have profound embodied consequences even for those who achieve relatively greater success in meeting biomedical breastfeeding recommendations. In the fifth chapter I examine men's contributions to breastfeeding and document their manifold support without which breastfeeding would not have been sustainable for most mothers in the study. I show that men's vital support for breastfeeding constitutes an important kin-making process that simultaneously helps overcome structural and cultural barriers to breastfeeding and mitigates the effects of stigmatization. Furthermore, this "kin work" plays an important part in the construction of fathers' personhoods and the fashioning of social class.

The final two chapters bring nighttime concerns to the forefront of analysis. The sixth chapter investigates the house as a primary site for consolidating and renegotiating middle-class cultural models of personhood and family relationships. My ethnography illustrates how the process of negotiating nighttime breastfeeding and sleep disrupts cultural expectations for children's personhood and kin relations that are built into the very structure of the house. In a similar vein, in the seventh chapter I address the radical disjunctures between cultural models of nighttime, which are heavily influenced by capitalist labor practices, and the disruptive modes of temporality posed by the experiences of nighttime breastfeeding. Parents' experiences of moral ambivalence that arose in the struggles of navigating these conflicts renegotiated these modes of space and time, reshaped their models of personhood and relations with one another, and subtly reworked the effects of capitalism in families' everyday lives.

In the conclusion, I share my key insights into the cultural, historical, and structural reasons behind the controversies that surround breastfeeding in the U.S. Ultimately, I hope to show readers that careful anthropological research can transcend divisive media debates and reveal mothers' and their partners' struggles to negotiate the cultural dilemmas that arise from negotiating an embodied practice that is at once revered, unsupported, and stigmatized. These families' efforts to breastfeed reproduce social inequities even while they simultaneously challenge some of the pervasive effects of neoliberal capitalism, linking their local embodied practices to global political economic and cultural forces. Finally, I draw on these insights to suggest more effective ways to support breastfeeding families.

Notes

1. All names in the book, including that of the city itself, and any details that would potentially identify specific persons have been changed in order to protect participants' confidentiality.
2. Wright and Schanler 2001; Crowther, Reynolds, and Tansey 2009; Grummer-Strawn and Shealy 2009.
3. Galtry 2000, 2001, 2003; Galtry and Callister 2005; Li et al. 2005; Calnen 2007, 2010.
4. See, for instance, Wolf 2007, 2011; Hausman 2003, 2011; Stearns 2010, 2009; Rosin 2009; Kukla 2006, 2005; Blum 1999; Carter 1995; Murphy 2004, 2003, 2000, 1999; Lee 2007, 2011; Lee, Macvarish, and Bristow 2010; Knaak 2010; Wall 2001; Schmied and Lupton 2001; Lupton 2000.
5. See chapters 1 and 2.
6. Hausman 2003, 2011.
7. See Gram 2009; Foster 2010; Hess 2011; Knowles 2012. The fact that breastfeeding and breastmilk can also generate sexual arousal and play a role in pornography as well as in other sexual practices contributes to perceptions of the sexual qualities of breastfeeding as inappropriate or transgressive (Foss 2012; Giles 2003; Bartlett 2005; Bartlett and Shaw 2010).
8. Gowen 2009; Cook 2010.
9. Jojo329 2009.
10. Hausman 2003.
11. Hausman 2003, 2011.
12. Attachment parenting is a philosophy of parenting based on psychological research on the significance of early, secure attachments to caregivers in child development and later adult well-being. This approach emphasizes that being responsive to the child's needs and providing

- consistent loving care enables children to form secure attachments (Attachment Parenting International 2008). I discuss Sears and attachment parenting in greater detail in chapter 2.
13. “Co-sleeping” is the term my participants as well as most media reports on this subject use to describe bed-sharing sleep arrangements. McKenna, Ball, and Gettler (2007) have argued that because sleeping in a proximal configuration—within arms’ reach—is possible on other surfaces, the two terms “co-sleeping” and “bed sharing” should be separated in order to specify the context of each arrangement. I follow his suggestion in my own usage throughout this paper, specifying the configuration of co-sleeping, but retain participants’ original language in quotations.
 14. Lowen 2012; M. Williams 2012.
 15. Jamie Lynn Grumet, the mother featured on the *Time* magazine cover, has been critical in her blog about her portrayal both on the cover and in the accompanying article (Grumet 2012) as well as in news interviews. She has recently appeared on the cover of *Pathways to Wellness* with an accompanying article that clarifies her position, her aim to reduce stigma for breastfeeding, as well as her larger goal of raising awareness about orphans and HIV among children in Ethiopia (Reagan 2012). Unlike in the *Time* magazine cover, where she did not have the right to select the image for the cover, she retained this right for the *Pathways* cover. On this latter cover, Grumet is depicted breastfeeding her now four-year-old son, lovingly embraced by her husband and other child, who is adopted from Ethiopia.
 16. Ball and Volpe 2012.
 17. Kendall-Tackett, Cong, and Hale 2010.
 18. McKenna, Ball, and Gettler 2007.
 19. Willinger et al. 2003; McCoy et al. 2004; Kendall-Tackett, Cong, and Hale 2010.
 20. AAP Task Force on Sudden Infant Death Syndrome 2005, 2011.
 21. Fallone, Owens, and Deane 2002; Zimmerman and Bell 2010.
 22. Ball and Volpe 2012.
 23. Throughout the book I use the term “biomedicalization” and “biomedicine” to refer to the rise in global prominence and local manifestations of a particular system of medicine that arose in Western Europe in the seventeenth and eighteenth centuries. Lock and Nguyen (2010:57–82) describe these changes, their antecedents, and contemporaneous modes of medicalization elsewhere in the world and use the term “medicalization” in these descriptions. Throughout their text, however, they carefully distinguish “biomedicine” as a specific medical system. Clarke and colleagues (2003) employ “biomedicalization” to distinguish a more recent period in medicalization characterized by the rise of technoscience in contemporary medicine. In contrast, I use the term biomedicalization even in the context of earlier historical periods to specify the medical system to which I refer in an effort to distinguish

- it from the professionalization of medicine undertaken in ancient Egypt or nineteenth century Japan, for instance.
24. See Ginsburg and Rapp 1995; Davis-Floyd and Sargent 1997; Clarke et al. 2003; Browner and Sargent 2011; Lock and Nguyen 2010.
 25. For instance, see Apple 2006; Murphy 2003.
 26. See, for instance, Metzl and Kirkland 2010; Lupton 1995; Rose, O'Malley, and Valverde 2006; Murphy 2000 on the neoliberal governance of risk in health.
 27. On the relationship of reproductive bodily processes and the reproduction of the nation, see Ginsburg and Rapp 1995; Lock and Kaufert 1998; Browner and Sargent 2011.
 28. This study was carried out with Institutional Review Board approval from the University of Michigan.
 29. This stands in contrast to the brief weeks or few months of breastfeeding carried out by the majority of Americans.
 30. Several authors have explored this concept in relation to reproduction. See Orit Avishai (2007) for a contemporary discussion of breastfeeding, Judith Walzer Leavitt (1986) on the history of childbirth and Jacqueline Wolf (2001) on the history of breastfeeding in the U.S.
 31. See chapter 2.
 32. Initially, I had planned to undertake a comparative study of two groups of parents: one that planned to bring their babies into their beds and another that did not. These goals were shaped by indications in my preliminary research that such groups might exist in the Green City area. However, I was not able to find parents who planned to bring their children into their beds. While four couples included the possibility of such arrangements within their plan, and one couple made these plans more explicit, none made a full commitment to such a plan and all purchased additional sleep equipment. Therefore, I altered my study to accommodate my participants' plans and practices. My attempts at finding a group of participants who planned to bring their babies into their beds are also reflected in the greater number of participants I recruited from one particular childbirth education site ("Holistic Center"). Based on my research, I anticipated finding more couples with explicit bed-sharing plans in courses at this site and therefore attended additional childbirth education sessions there to carry out my objective.
 33. The median income was approximately \$44,500 in the state and \$42,000 in the U.S. at the same time (U. S. Census Bureau 2000).
 34. Nearly nine out of ten Green City residents possessed some level of education beyond high school (compared with 51 percent in U.S.), with four out of ten having master's, professional, or doctorate degrees (8.9 percent in U.S.) (U. S. Census Bureau 2000).
 35. Approximately 85 percent initiation rate v. 67 percent in the state and 72 percent in the U.S. at the time of my research (CDC 2010a, 2010b).
 36. Bobel 2001.
 37. See Elias et al. 1986; La Leche League International 2007.

38. Considered by U.S. standards.
39. See McKenna, Ball and Gettler 2007 for a review.
40. Here I mean “mothers to living children.” The term “mother” is a problematic distinction, since several participants had suffered pregnancy losses prior to their first live births.
41. A few interviews were not recorded because of initial discomfort with the recorder and due to recorder malfunction.
42. The potential use of the log originated from Ball and colleagues (Ball, Hooker, and Kelly 1999) study, but it was not systematically implemented in my own work. Indeed, the log yielded different kinds of ethnographic insights, explored in chapter 7.
43. Although the 2005 recommendations suggested exclusive breastfeeding for the first six months and continuing with breastfeeding through the first year of the baby’s life, on-line resources and in-person interactions with medical staff often gave parents different messages that failed to highlight the importance of exclusive breastfeeding and the total duration of breastfeeding.
44. See comparative statistical information in CDC 2010a, 2010b; Willinger et al. 2003; McCoy et al. 2004.
45. Rapp 2001; Ginsburg and Rapp 1995; Davis-Floyd 2004; Layne 2003, 1996.
46. Brondo et al. 2009; Wasson et al. 2008.
47. Brown and de Casanova 2010; Barlow and Chapin 2010; and previous note.
48. See Narayan 1993; Jacobs-Huey 2002; Bunzl 2004.
49. See Armbruster and Laerke 2009 for a recent review of these discussions.