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ARTICLE

"I See No Other Option:" Maternal Practices of Sleep-Training and Co-Sleeping as the Management of Vulnerability

Sara Howson

Bar Ilan University, IL
saradvora613@gmail.com

This article proposes to investigate maternal practices concerning infant sleep from a feminist perspective, with particular attention to the growing critical interest in vulnerability. The topic of baby sleep and the practices that should be employed to manage it is one of the most controversial topics of paediatric research and parenting advice. It is also an issue that causes division between mothers. Opinion is polarised into two camps, one recommending independent sleep achieved through practices of sleep-training that involve leaving babies to cry; the other that encourages practices of 'co-sleeping' and attentive and responsive night-time care often achieved through mother and baby sharing a bed. In this article, I argue that both advocates of sleep-training and co-sleeping are seeking to offer neoliberally-informed individual solutions to social and political problems. I argue that baby sleep and the maternal practices employed to manage it have to be understood as strategies for managing human vulnerability in a culture and political environment that seeks to ignore it. I suggest that the debate between sleep-training and co-sleeping can be better understood through a consideration of care relations and the care deficit in post-industrial society. I argue that attention also needs to be given to discourses of medicalised childcare, and how the subject positions of mothers and babies are deeply troubled in a society where subjectivity is equated with independence.

We are happier and the baby is happier and healthier now. I can't stress this enough to new parents [...] it's OK to let your baby cry a little. It's the most natural thing in the world. Don't go running to them at top speed the second they make a peep or it will set them up for failure down the road. Let them learn patience and self-soothing and they will be healthier for it (Cbunz 2014, website comment).

Last night he cried longer and when I went into his room there was vomit everywhere! I was mortified and felt so so so bad. I felt like a bad mother and was later reduced to tears (Jess 2014, website comment).

I know he is capable of learning to fall asleep alone, just like he does at night [...] I never thought we'd be here, but I see no other option, and honestly, he was just as happy to see me this morning as he ever is. I am not a bad mother. This isn't selfish. My darling boy needs to rest, and rest well, and I want to help our whole family feel rested (Mrs Goins 2014, website comment).

This article proposes to investigate maternal¹ practices concerning infant sleep from a feminist perspective, with particular attention to the growing critical interest in vulnerability. Baby sleep is one of the most controversial issues in modern parenting, both among parents themselves and in the scientific and popular literature (Hiscock & Fisher 2015; Ramos & Youngclarke 2006). A majority of parenting experts support sleep-training practices (Ramos & Youngclarke 2006). A significant minority argue against sleep-training and in favour of alternative practices like co-sleeping or bed-sharing (Ramos & Youngclarke, 2006). In this paper, I hope to challenge the existing

¹ I recognise that not everyone who cares for a baby is a mother and that the term maternal practices might be considered exclusive. I use it in the context proposed by Ruddick (1995), who uses the term 'mothering' to refer to the care of children regardless of whether it is undertaken by mothers or other carers. In her eyes and in mine too, it is to continue to use language of mothering in recognition that the majority of mothering work has been performed by women and continues to be performed by women. A term like 'parenting' whilst used sparingly in this article, neuters women's mothering and gives the inaccurate suggestion that baby sleep practices equally shared responsibilities by men and women and erases the embodied and sexually specific aspects of baby sleep, for example the relation to breastfeeding, that need to be considered in a feminist politics of maternity.

terms of debate on both sides. Regardless of the relative merits of both sets of arguments, I argue that important political questions, specifically questions about vulnerability and how we manage it in post-industrial societies, are sidestepped when we reduce this debate to contradictory bodies of scientific evidence. The current attempts to conduct this debate on the terrain of the 'biological' or the scientific are reductionistic in nature and continue the long tradition of reducing the maternal to the natural and excluding it from the realm of culturally or politically significant human behaviour.

In place of attempts to rehash the contradictory scientific evidence in favour of or against practice of sleep-training, I argue that baby sleep and the maternal practices that are engaged to manage it are properly political issues, which highlight the vulnerability of mothers, parents and infants in ways that are important to feminist politics in the twenty-first century. To begin, I outline the debate about sleep-training and co-sleeping in popular discourse and the scientific literature. In the next section, I discuss three key issues that are not addressed or are inadequately addressed in the debate as it currently exists: the 'care' deficit that has emerged in Western societies; the power imbalance between medically-informed experts who lead opinion about maternal practices and the mothers who chose and implement them; and the troubled subject positions of both mothers and babies as vulnerable beings in a society that refuses to acknowledge the political relevance of human vulnerability and dependency (Kittay 1999; Hoffmaster 2006; Tronto 1993).

Background

Parenting 'experts', medical practitioners and parents themselves² are often polarised into one of two competing positions with regards to maternal practices surrounding baby sleep (Hiscock & Fisher 2015; Ramos & Youngclarke, 2006). The majority

² I myself am not uninvolved in this debate. As a mother, I too have had to choose maternal practices and this involves an element of 'taking sides'. While I do not uncritically align myself with the 'natural parenting' movement, I do co-sleep with my son and engage many 'natural parenting' practices. I am largely convinced by the scientific literature that supports these practices. However, throughout this article, my primary goal is not to defend my position, but rather to explore the topic through the lens of vulnerability with attention to the methods employed by *both* sides of the debate to manage infant

of advice concerning infant sleep promotes a practice called sleep-training, which suggests that infants can be taught to sleep and to 'self-soothe' if they are encouraged to do so by parents (Hiscock & Fisher 2015; Ramos & Youngclarke 2006). In practice, this encouragement often takes the form of allowing the baby to cry, usually for specified periods of time, and the withholding of comfort from the child in the belief that the child will learn to soothe themselves (Hiscock & Fisher 2015). A significant minority of parenting 'experts' advocate for practices such as co-sleeping (Ramos & Youngclarke 2006), bedsharing and 'breast-sleeping' (McKenna & Gettler 2016).³ These practices see mothers make themselves available to comfort their children at night, often by sharing a sleeping space or surface with their child (Ramos & Youngclarke 2006). This approach teaches mothers to 'follow their children' and take their cues about sleepiness, hunger and other needs, and as such demands the physical presence and responsiveness of the mother (Büskens 2001; Hiscock & Fisher 2015; Ramos & Youngclarke 2006).

In popular parenting and medical literature, this debate is gridlocked (Ramos & Youngclarke 2006). Mothers are often fiercely defensive of their maternal practices and engage in the policing of the practices of others, often engaging in critical judgements and comparisons of one another's practices and children (Lupton 2011). Both sides are keen to cite scientific studies that indicate their practices are evidence-based (Ramos & Youngclarke 2006). Unhelpfully, both sides engage different bodies of scientific literature (Hiscock & Fisher 2015). Co-sleeping practices are based on attachment theory and draw heavily on evolutionary biology and anthropological sources to determine human sleep behaviours (Bartick, Tomori, & Ball 2017; Büskens

and maternal vulnerability.

³ Co-sleeping can refer to a range of practices and is often used ambiguously. Some have attempted to separate co-sleeping from bedsharing, suggesting that co-sleeping should properly refer to mothers sharing a room with their child but not a sleep surface or using a special 'co-sleeping' crib that attaches to the parent's bed. Bedsharing refers to the child sharing a sleeping surface with the mother. Breastsleeping, a term coined by James McKenna, refers to the sleeping-feeding interactions of breast-feeding mothers and infants at night and presumes a shared sleep surface. Throughout the article, for clarity, I will refer to all of these practices under the heading of 'co-sleeping' in that they are all framed as alternatives to sleep-training, involve parental responsiveness to infants at night, and do not involve early independence training.

2001; McKenna & Gettler 2016). The growing field of psychology and endocrinology of attachment also supports many of the claims made by co-sleeping advocates, who are able to cite studies indicating that infants left alone have elevated stress hormones even after they learn not to cry (Middlemiss, Granger, & Nathans 2012) and that over time, that this may impair brain development (Bartick et al. 2017) as a result of 'toxic stress' (Shonkoff et al. 2012). Sleep training practices are based on theories of behaviour modification (Hiscock & Fisher 2015). This group is able to point out that 'randomized trials of behavioural sleep-training interventions that involve crying consistently demonstrate moderate success in preventing or eliminating night-wakings in toddlers' (Ramos & Youngclarke 2006, p. 1618). As the web comments above show, parents advocating sleep training often are able to demonstrate that their own wellbeing as parents has increased since their child was sleep-trained, a consideration that medical practitioners take seriously, particularly in light of concerns about post-partum depression and maternal mental health (Hiscock & Fisher 2015).

The polarisation of opinion in the scientific community means that whatever practices a given family chooses, there is at least one body of well-publicised scientific literature that indicates against the chosen practice. The debate is moralised in terms of the figure of the bad mother – the mother who does not make herself available to her child constantly is a 'bad mother' for not attending to her child's emotional needs (Büskens 2001). However, those who practice alternatives to medically-recommended sleep-training, particularly when they couple this with the suite of practices associated with attachment parenting, such as full-term breastfeeding and breastfeeding on demand, also face criticism for jeopardising their child's wellbeing, their own wellbeing and relationships within the family, particularly with male partners (Moore & Abetz 2016). The vilification of mothers on both sides of the debate is often undertaken by other mothers (Moore & Abetz 2016).

The Care Deficit and Baby Sleep Anxiety

In her important book, *The Commercialisation of Intimate Life*, Arlie Hochschild (2003) describes how modern Western societies are experiencing a care deficit as a result of the reorganisation of domestic and workforce labour in modern families. Hochschild (2003) notes that over the course of the twentieth century, care in West-

ern societies has been reorganised in significant ways. This is part of broader shifts in social relations over the twentieth century that saw the replacement of extended networks of kinship with the 'conjugal family', consisting of husband, wife and children. The network of women working together to provide for the care needs of a family was replaced by the housewife, alone in her home, responsible for raising children and caring for her husband (Hochschild 2003). She also was responsible for the entirety of the home's domestic labour, a feat made possible through mechanisation. Following the brief era of women's lonely domesticity, women began entering the workforce in large numbers, and the two-job family became the norm (Hochschild 2003). However, women continue to bear more responsibility for household labour than men (Bureau of Labor Statistics 2017). There has been no systematic replacement of the networks of care-giving and support that existed among women prior to industrialisation (Hochschild 2003). The option to outsource care to others, often less-privileged women, remains the preserve of the privileged few (Hochschild 2003). The result as Hochschild (2003) notes, is a tightening of care resources, with fewer people available to do the work of caring.

The care deficit has had a profound effect, not just on those receiving care, but also on those who are carers. Eva Kittay (Kittay 1999, p. 46) describes the concept of 'secondary dependency' to describe the accrued vulnerability experienced by someone who is responsible for the care of another. The clearest form of secondary dependency in Western society is the financial dependence of mothers. Mothering has no economic value in our society and therefore mothers must either find work that accommodates their care commitments or rely on others – usually a male partner – to provide for their financial needs in order to 'allow' them to perform their care work. Single mothers are much more likely to be in poverty than women with partners (Dawn 2018). Most Western societies have been reluctant to address the economic vulnerability mothering entails. Instead the problems that emerge are addressed as individual problems to be solved through efficient management of personal resources. This is in keeping with the neoliberal project that generates an entrepreneurial model of the self (Read 2009), wherein the individual is made responsible (or 'responsibilised') for managing their personal resources in order to achieve their goals

and ensure their wellbeing (Read 2009). The application of neoliberal discourses to parenting decisions leads to the assumption that parents have a high level of parental control over their children (Wall 2013). Whereas once a baby who didn't sleep much might have been considered bad luck, through the frame of neoliberal personal responsabilisation for all life outcomes (Baker 2010), the awake baby and tired parents come to be understood as a failure to make correct choices to ensure the family's welfare. Thus, maternal practices around baby sleep can be understood in the context of neoliberalism as individual solutions to social problems created by the care deficit.

Hochschild (2003) notes that the family is in many ways a pre-industrial institution and runs on personal, rather than industrial time. Babies are notoriously unaware of 'clock time' and are not driven by efficiency. Children dawdle, babies cry, toddlers refuse to have their nappies changed. Babies wake up at night, sometimes to feed, sometimes to play, sometimes inexplicably. Night-wakings are normal in babies (Goodlin-Jones, Burnham, Gaylor & Anders 2001). However, in a society driven by industrial time and efficiency, these behaviours become highly problematic. In fact, over the course of the twentieth century, concerted attempts were made by medical professionals advising mothers to insist on industrial-time based schedules in the care of babies, including the now notorious four-hour feeding schedule (Büskens 2001). Guides that instruct mothers to schedule sleep, a characteristic of many sleep-training proponents (see for example Ferber 1985; Ford 2013; Weissbluth 2015), can be understood as a continuation of this trend, which has been termed 'rationality/efficiency' parenting (Büskens 2001). Rationality/efficiency parenting can be understood to refer to maternal practices that aim to limit the provision of care and effect a subsequent decrease in expressed care needs (Büskens 2001), producing a child care practice that is manageable in the context of industrial societies and the care deficit.

It is important to note that this orientation towards rationality and efficiency should not be understood simplistically as lacking in compassion. In the context of a two-job family where the family sees both incomes as necessary to survival, a baby that leaves its mother unfit to wake up at 7am for work is a liability. Similarly, in a two-job family where the mother is already shouldering the burden of the majority of domestic labour and caring for her husband, a baby that needs more care is a baby

who creates a mother who is more dependent on those around her. Increasingly, there are few people around her who are willing to provide needed care. Sleep 'solutions' whether they be sleep-training advice designed to *Solve Your Baby's Sleep Problems* (Ferber 1985), or the *No-Cry Sleep Solution* (Pantley 2002) that is offered as an alternative to sleep-training, are private solutions to problems that emerge from the organisation of care and work in our societies.

The opportunity for a mother to 'opt out' of industrial time and place herself and her baby in a situation where sleep can be organised creatively is an economic privilege. The option to work from home, for example, is associated with holding an advanced degree (Bureau of Labor Statistics 2017). The opportunity to stay home is most commonly provided by wage-earning partners. Practicing co-sleeping requires the maintenance of a breastfeeding relationship as it is considered unsafe for non-breastfeeding parents to co-sleep (Bartick et al. 2017). The continuation of breastfeeding itself can be understood as an economic privilege. Maternity leave (Berger, Hill & Waldfogel 2005) and part-time work (Fein & Roe 1998) have all been associated with helping mothers and babies maintain their breastfeeding relationship. The ability to organise sleep in ways that accommodate night-wakings (going to bed early, sleeping in, napping) are more available to mothers who are able to opt-out of industrial time by staying at home, working at home, organising flexible work or paying for household help or childcare assistance.

This might be part of the reason for the peculiar finding that emerged from the meta-analytical research by Ramos and Youngclarke (2006, p. 1622), who in surveying literature on advice to parents about baby sleep, found that '82% of books advocating cosleeping claim that it helps parents get more sleep, yet 65% of books opposing cosleeping claim that it interferes with adult sleep'. Whilst Ramos and Youngclarke (2006, p. 1622) quickly demand more 'objective research' in the area to clear up such contradictions, it is also entirely plausible that this 'contradiction' is reflective of different demands faced by mothers. Goldberg et al., demonstrate through a longitudinal study of the association of baby sleep behaviours and maternal health outcomes that 'whether infant sleep disruptions are considered problematic depends on factors such as parental psychopathology, social values, and cultural

norms' (Goldberg, et al. 2013, p. 102). They point to the important role that parental expectations play in determining whether a sleep behaviour is a problem or not. This study, however focuses on how maternal mental health and how the presence of 'multiple life stressors' (Goldberg et al. 2013, p. 107) affects tolerance for night-waking behaviour. Their recommendations involve the treatment of 'maternal symptoms' (Goldberg et al. 2013, p. 107). What is not considered within the framework of this medically-oriented study is that life-stressors for women in the context of the care deficit are informed by the political organisation of care in our societies. We scarcely need longitudinal studies to confirm that the single mother who has to attend her work as a waitress in a café at 7am and drop her baby off at her mother's home at 6.30am will likely find a 12am wake up more disturbing than a mother who also wakes up at 7am but spends the first hour of her morning making coffee and checking emails while her home-help service cleans the bathrooms.

Advocates of co-sleeping are also usually advocates of breastfeeding and other practices, like babywearing, that are associated with promoting strong attachments between mother and infant (see for example Sears & Sears 2001). There is research that suggests that these practices lead to better wellbeing for mothers and babies (see for example Bartick et al. 2017; McKenna & Gettler 2016). The natural parenting movement, including advocates of co-sleeping, often seek to spread this information to mothers to encourage them to make 'natural' parenting choices (Büskens 2001). However, this information is often shared without any reference to the structural aspects of our society that make these choices difficult (Büskens 2001). Instead, the debate is framed in bluntly neoliberal terms as being about 'choices' without any consideration of the structural constraints that shape behaviour (see for example this study of mothers in the natural parenting movement by Reich 2014).

If, as advocates of co-sleeping suggest, there are vast benefits for the wellbeing of children to be gained from practices of breastfeeding and co-sleeping, it is not enough to simply 'encourage' mothers to take them up. To do so is to embrace the neoliberal paradigm of proposing individual solutions to social problems. Framing parenting as a collection of free choices, without consideration of social constraint, also places enormous pressure on mothers to address vast political concerns such as

the care deficit in Western societies within their own personal resources. The political organisation of care informs and shapes maternal practices around baby sleep in important ways. Any dialogue about the benefits of co-sleeping or breastfeeding, or the disadvantages of sleep-training needs to be undertaken in the context of a recognition of the urgent need for political and economic recognition of care-needs and the secondary dependencies accrued by care-takers.

Vulnerability of Mothers in the Medicalised Model of Childcare

Over the same period that intergenerational and communal networks of care were being dismantled, the medicalisation of pregnancy, birth, childhood and mothering accelerated dramatically (Afflerback, Anthony & Grauerholz 2013; Apple 1995; Clarke 2013; Lee 2016; Litt 1996; Ryan & Grace 2010; Simonds, Rothman & Norman 2006; van Teijlingen, Lewis, McCaffrey, Porter, 2004; Wall, 2013). The new model of family care, which saw the mother in the home with her children alone, did not extend decision-making power over her children to her (Apple 1995). Over the course of the twentieth century, in concert with other patterns of medicalisation, the role of the mother came to be understood as implementing best practices as devised by doctors (Apple 1995). As Apple (1995, p. 162) states, the ideology of medically-led childcare:

Presented women with a tension-laden contradiction: it made them responsible for the health and welfare of their families, but it denied them control over child rearing [...] women were both responsible for their families and incapable of that responsibility.

Doctors now had opinions on all kinds of things that had previously been the preserve of women, from how long a baby should sleep to what was the right time to start feeding the baby vegetables (Apple 1995). The doctor's orders were communicated to mothers through a range of means, from public health initiatives, to the new baby manuals which provided explicit instructions for basic tasks like feeding and sleeping, through visits to the doctor that were now a staple of babyhood and also, importantly, through advertising (Apple 1995).

This trend towards the medicalisation of a baby's development was reflective of the wider trend in Western societies towards 'surveillance medicine', a new approach to health management that applies the principles of clinical medicine to whole populations, including those who are not presenting illness (Armstrong 1995). Surveillance medicine is driven by risk-awareness, and increasingly the medical care of otherwise healthy pregnant women, birthing women, and mothers and infants came to be understood in terms of risk (Simonds et al. 2006). No longer was childhood a stage of life that unfolded according to a regular pattern. Rather, through the paradigm of surveillance medicine and risk orientation, childhood was a time rife with the risk of abnormal development (Afflerback et al. 2013; Lee 2016; Lupton 2011; Wall 2013). Increasingly, the role of the mother came to be understood in terms of this risk. Mothering transformed into modern 'intensive mothering', a high-stakes project supervised by experts and administered by mothers (Afflerback et al. 2013; Apple 1995; Büskens 2001; Knaak 2016; Lee 2016; Williams, Donaghue & Kurz 2012).

The promotion of medicalised, intensive mothering through medical discourse also advocates an understanding of the child as profoundly vulnerable (Lupton 2011). Babies especially, are conceived of as needing intensive care and protection from external contamination (Lupton 2011). Within a neoliberally-oriented medicalised model of childcare, the vulnerability of children is managed through the individual responsibility of mothers to protect their vulnerable children, through the implementation of medically-indicated best practices (Lupton 2011). A political conception of the vulnerability of children, that demands attention not just from maternal caregivers, but from society more broadly and which also addresses maternal secondary dependencies is notably absent from existing discourse about infant care.

One of the major consequences of the 'intensive mothering' project in the context of baby sleep is the transformation of events that might have been understood as a part of life, for example, infants' night-wakings, are produced through surveillance medicine as 'problems' or 'risk-factors' that can be addressed through medical solutions. Prior to the late nineteenth century children's sleep issues were not discussed in literature dealing with childcare (Stearns, Rowland, & Giarnella 1996). The

'problem of baby sleep' thus emerged at the same time as medical recommendations and cultural norms shifted towards solitary sleep for infants (Bartick et al. 2017). It is also notable that this is the same time period in which the 'conjugal family' replaced extended networks of caregiving (Hochschild 2003). Sleep issues can thus be understood as produced in the context where solitary sleep became culturally desirable and where resources for the care of children were increasingly restricted.

These social conditions are medicalised by the dominant medical discourse that encourage sleep training practices through the expansion of the definition of a 'sleep problem' to incorporate any behaviours that are problematic to parents. Night-waking is normal behaviour for human babies (Goodlin-Jones et al. 2001), however, this behaviour has increasingly been understood as a problem within the medical community. Sleep training advocate Richard Ferber (1985, p. 8) writes: 'if your child's sleep patterns cause a problem for you or him, then he has a sleep problem'. A recent study by Hiscock and Fisher (2015) promoted the use of sleep-training methods with very young infants and argued that the definition of a 'sleep problem' in a baby should be expanded to include any issue which parents report as disturbing (Hiscock & Fisher 2015). This was despite the authors' own acknowledgement that parents have developmentally inappropriate and unreasonable expectations about their children's sleep (Hiscock & Fisher 2015). The authors argue that these 'problems' should be recognised as such because they place parents at risk of problems with their own well-being, such as post-partum depression (Hiscock & Fisher 2015).

This orientation towards defining sleep problems as that which causes parental discomfort, even if such behaviours are normative, can be understood as a clumsy attempt to recognise the secondary dependency of mothers and other carers, who are affected by their infant's sleeping habits. However, it is interesting to note that Hiscock and Fisher (2015) limited their recommendations to proposing the expansion of sleep-training interventions designed to change the behaviour of infants, despite their own acknowledgement that these behaviours are developmentally normal. No other measures were recommended. It appears that in the case of this medical response to challenges to maternal wellbeing that are created by the vulnerability

of infants and the secondary dependencies of mothers, the appropriate response is to create more 'efficient' babies who are sleep-trained and demand less of their carers. I have been unable to find a medical study that mandates that mothers of young children perform no care work for adult males, or refrain from domestic labour during the first months of their child's life, or recommend that policy makers consider nationally-funded schemes to offer household assistance to new parents. It seems that these recommendations are at least as reasonable a solution as expecting two-month-old babies to curb developmentally appropriate behaviours.

The 'intensive mothering' model of childcare, with its inherent anxiety and risk-awareness, responsabilises mothers for following advice given to them by 'experts' and as such positions medical doctors as the foremost authority in childcare decision-making (Apple 1995; Lee 2016; Lupton 2011). One consequence of the authority of medical discourse in the field of baby care is that it is challenging for mothers, living outside of the controlled environment of clinical medicine and facing issues of limited resources in the context of the care-deficit, to follow much of the advice provided by medical professionals, especially as it pertains to sleep. The current recommendation of the prominent American Academy of Pediatrics (AAP) is that babies should *never* share a sleep surface with parents (Bartick et al. 2017). However, in a survey of 5000 mothers, 60% reported that they did bedshare and 25% reported that they had fallen asleep with their infants on unsafe sleeping surfaces, like sofas or lounge chairs and that this had often happened as a consequence of attempts to avoid bedsharing (Kendall-Tackett, Cong, & Hale, 2005). There is a significant scientific opinion that suggests that bedsharing can be safely practiced and can be preferable to solitary sleep (Bartick et al. 2017). Nonetheless, recommendations for completely separate sleep for infants remain mainstream, despite the indications that a large number of parents have significant difficulties following such directives (Bartick et al. 2017; Kendall-Tackett et al. 2005; McKenna & Gettler 2016).

Other common aspects of sleep-training are also hard to implement. Regimented sleep schedules demand a high level of maternal control over all aspects of life, which is not always possible. Listening to an infant in distress is difficult for many

mothers. Comments on a blog post recording the experiences of mothers who sleep-train, some of which are quoted at the beginning of this article, demonstrate that for at least some mothers it is extremely difficult to listen to their child cry and that they experienced strong negative emotions seeing the consequences of their child's distress, for example, when infants vomited in their cribs ('The Ferber vs. Weissbluth CIO Smackdown', 2012). The fact that Richard Ferber in his sleep training manual refers at length to overcoming and analysing feelings of guilt associated with crying indicates that this is a significant concern for parents (Ferber 1985).

Advocates of co-sleeping and opponents of sleep-training sometimes try to argue against this practice from a scientific and medical perspective, focusing on the damaging effect of stress hormones on babies (Bartick et al. 2017). However, very little attention is drawn to the affective experience of mothers surrounding this practice. Indeed, other mothers and advocates of sleep training encourage mothers to overcome their feelings of guilt about their child's distress and to examine their own behaviour for any emotional benefit they might be getting from responding to their children's cries (Ferber 1985). This follows the well-established trend of discounting the emotional in the face of the 'rational', particularly where the emotional is associated with women and maternity (Jaggar 1989; Lloyd 1984). It is an issue of feminist concern that we still lack a language for talking about the psychic experience of maternity without reductionist recourse to 'hormones' and 'instinct' (Faircloth 2011) or the dismissive rejection of 'feelings'.

Co-sleeping also presents a range of challenges that are not adequately addressed by its advocates. As co-sleeping is a practice that is not endorsed by important medical authorities, like the AAP (Ball et al. 2016; Bartick et al. 2017) co-sleeping often involves *resisting* the dominant medical discourse. As Lupton (2011) notes, it is not easy for mothers to take actions that run contrary to the aggregated medical opinions about 'best practices' that circulate in parenting advice and amongst mothers. Lupton (2011) points out that mothers are subject to surveillance from healthcare professionals, family and friends and are also actively engaged in the policing of the behaviours of other mothers. Co-sleeping therefore, tends to be practiced by mothers who are already interested in what has been termed the 'natural' parenting

movement (Büskens 2001), which is often associated with a scepticism towards 'conventional' medical opinion (Reich 2014).

Something which is rarely acknowledged in literature that encourages mothers to co-sleep is that different mothers are in different positions to challenge medical authority. Questions of social and cultural capital are extremely relevant to this discussion. Some mothers, such as the high-status, upper-middle-class mothers who were interviewed in a study of vaccine refusal, are in a powerful position to fend off criticism of their mothering practices (Reich 2014). However, mothers who lack such cultural resources are more vulnerable to the effects of criticism from both peers and authority figures. A mother who has held a successful job as a lawyer, argued in court and been the valedictorian of her graduating class is in a much better position to make some unusual choices about where her baby is going to sleep and how long he is going to breastfeed, and to defend those decision against the contradictory opinions of family, friends and the local doctor; than a teen mother who hovered on the brink of abortion, decided to have the baby and now is trying to complete high school in the evenings whilst regularly reporting to her social worker about her care of the baby. Advocates of co-sleeping would do well to recognise that women are vulnerable to claims that not co-sleeping will damage their child's development and couple their efforts to raise awareness about the benefits of co-sleeping with a political agenda that seeks to create the conditions that allow for the responsive and generous care of children. It should be noted that, increasingly some advocates of co-sleeping have begun to argue for paid leave policies in the interests of maternal and child wellbeing (Bartick et al. 2017).

The Subjectivity of Mothers and Babies

A final consideration, that will conclude this feminist analysis of maternal practices surrounding baby sleep, is the question of the subjectivity of mothers and babies. Concepts of the subject which have dominated Western philosophy and have remained prominent in medical discourse and Western culture more broadly are aligned with ideals of independence, agency and rationality (Butler 2004; Hoffmaster 2006; Kittay 2011; Tyler 2000; Young 1984). Each of these ideals has also historically been associ-

ated with masculinity and defined negatively against femininity (Grosz 1994; Lloyd 1984) and especially maternity (Boulous Walker 1998; Tyler 2000). Furthermore, dominant conceptions of subjectivity are often defined against corporeality, with the assumption that intrusion of the body into mental processes is a marker of weakness or impairment (Gatens 1996; Grosz 1994). The embodied states and psychic experiences of maternity, which involve the body, the emotions and a state of close interrelationality with another being are antithetical to the independence and agency of the dominant model of subjectivity.

This locates mothers in a problematic subject position. Büskens (2001) notes that contemporary culture actually demands that mothers occupy a pre-modern subject position, where their primary motives are collective rather than individual. In this context, the model of rationality/efficiency parenting (Büskens 2001), that seeks to reduce a baby's care needs, can be understood as an attempt to help mothers regain their own independence and thus reassert their troubled subjectivity. Independent babies allow for more independent mothers. Furthermore, as babies themselves cannot be 'proper' subjects because they are neither independent, clearly agentic or rational, their desires and distress regarding maternal practices can be easily dismissed.

In this context, we can understand more clearly why sleep-training remains the dominant maternal practice associated with baby sleep and why, as discussed earlier, the actual feelings of both mothers and babies are so readily dismissed by proponents of sleep-training. We have already noted that some mothers experience emotional distress during the process of sleep-training but continue with the practice. Infants who undergo sleep-training practices clearly experience distress and communicate it with their cries. Advocates of sleep-training argue that this distress is not serious and is both normal and necessary to learning healthy sleep habits (Ferber 1985). The distress of mothers is also cast as an emotional obstacle to be overcome in the promotion of the healthy sleep habits that are in the best interests of the child (Ferber 1985). I argue that this tendency to see the affective experiences of mothers and babies as *contrary* to the best interests of mothers and children, comes from an inability to recognise mothers and babies as subjects and this in turn is a consequence of the embodied, emotional and relational orientation of mothering. In *Precarious Lives*, Judith Butler (2004) describes how our philosophical understanding of what

establishes the proper subject also sets up our understanding of what distress is really distressing, or as she puts it which lives can be grievable. Mothers and babies, associated with the murky realm of the corporeal, the emotional and the dependent, cannot be recognised as adequate subjects within the dominant model of subjectivity that operates in Western societies. As such, they cannot establish grievable distress. Their distress associated with sleep-training thus remains exterior to the debate about maternal practices around baby sleep.

Furthermore, in the context of the dominant model of subjectivity we can understand more clearly why activities to promote an infant's early independence, even despite the recognisable distress of the children who undergo them, are framed as being in the best interests of the child (Ramos & Youngclarke 2006). We see this in the remarks by sleep-training advocates Pearce and Bidder that:

Believe it or not, leaving your child alone to cry in bed is a way to show your love and care for him [...] if you can help your child to get himself to sleep, you will be preparing him for a life of independence (Pearce and Bidder 1999, cited in Ramos & Youngclarke 2006, p. 1621).

As subjectivity is traditionally understood as occurring through a breaking out of the maternal realm of care and dependence (Boulous Walker 1998; Lloyd 1984) any step a child takes towards greater independence is both laudable and further establishes them as a subject. Furthermore, because mothering involves preparing the child for entry into society (Ruddick 1995), this early independence training can be seen as reflecting the child's best interests.

Thus, through the process of sleep-training, which seeks to limit the demands of an infant for night-time care and attention, the dependency of mother and baby are to some extent reduced. Sleep-training advocates promote the ideal of the baby who is independent at night (Ramos & Youngclarke 2006). Through this process of making the baby more independent, mothers themselves regain some of their lost independence, thus partially re-establishing their own troubled subjectivity. It has been noted that motherhood presents a cultural contradiction in contemporary Western societies, in that whilst valued and romanticised, mothering essentially puts women in a pre-modern subject position and they are unable to achieve the rationality, independence

and agency that is necessary for the recognition of subjectivity (Büskens 2001; Hays, 1998). Motherhood in this context becomes a carefully negotiated project, in which mothers must attend to their damaged subjectivity and live in discord with prevailing individualist values (Avishai 2007; Büskens 2001). As Büskens (2001) notes, in contemporary Western societies recognition and positive reflections come about as a result of individual achievements across a range of settings. Mothers, she argues, are not able to achieve this to the same extent as non-mothers, because of the significant time commitment of raising a small child. Often mothers feel immense pressure to regain their subjectivity and 'get their body back' from children who come to be viewed as parasitically robbing them of subjectivity (Schmied & Lupton 2001). In this context, the focus of rational-efficiency parenting on making children as independent as possible as fast as possible and the stringent efforts to manage the particularly unpredictable area of another human's sleep become a culturally understandable by-product of a social order in which subjectivity can only be recognised through independence.

Conclusion

Maternal practices surrounding baby sleep are an important issue in the lives of many mothers. Indeed, any gathering of mothers will usually include discussions of how much, or how little sleep everyone is getting. Maternal practices of sleep-training and co-sleeping will also likely continue to function as litmus tests that separate different 'tribes' of mothers and serve as a source of controversy both amongst mothers and within the communities of 'experts' that seek to advise them. This paper is offered as the beginning of a feminist consideration of this issue. Whilst not a comprehensive treatment of these complex issues, I have set out in this paper to reframe the debate about practices of sleep-training and co-sleeping in the context of feminist theory about vulnerability, care, medicalisation and subjectivity. I have also argued that both co-sleeping and sleep-training are most productively considered as strategies for managing the vulnerabilities of mothers and infants in societies where vulnerability is excluded from political discourse. As a consequence of our dominant model of subjectivity and the corresponding unwillingness to politically address issues of vulnerability, both co-sleeping and sleep-training primarily continue to be offered as individual, medicalised solutions to complex social problems.

I have sought to argue that feminists should be concerned by the fact that many mothers are resorting to the emotionally gruelling practice of leaving their babies to cry, while no one is asking if all this distress and anxiety about babies sleeping is necessary. Those who advocate against sleep-training and in favour of practices of co-sleeping, have not done the important work of recognising that in many cases the choices they advocate for are made easier from a position of social, cultural and financial privilege. Advocating for these solutions and in particular drawing attention to the 'dangers' of sleep-training without recognising these issues of privilege further responsabilises individual mothers for social problems. These discussions need to be framed in feminist, political terms. There are political solutions, beginning with the economic recognition of mothering work, that might leave no-one crying – or at the very least – would not place mothers in the unenviable position of saying: 'I see no other option'.

Competing Interests

The author has no competing interests to declare.

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