

Article

Institutional Control, Biopower, and Symbolic Stigma: Applying the Sociology of Deviance to Breastfeeding Refusal and Cessation in Spain

Pilar Teruel-Francés ^{1,2}, Isabel Morales-Moreno ^{3,*}  and José Manuel Hernández-Garre ³ 

¹ Andalusian Health Service, 41020 Seville, Spain; conairesdelsur@yahoo.es

² Hematologic Ambulatory Hospital, Regional Hospital of Málaga, 29010 Málaga, Spain

³ Faculty of Nursing, Catholic University of Murcia, 30107 Guadalupe, Spain; jmhernandez@ucam.edu

* Correspondence: imorales@ucam.edu

Abstract

Discourses on breastfeeding extend beyond simple scientific evidence, framed within a dialogue between diverse sociocultural perspectives throughout history. Building on this premise, this article aims to explore, from the perspective of the sociology of deviance, the maternal experiences of women who choose not to breastfeed or cease breastfeeding within the hospital setting. To this end, this qualitative and phenomenological study was conducted, using semi-structured interviews with mothers in the municipality of Lorca who had decided not to breastfeed or had discontinued breastfeeding as a data collection tool. The results indicate that breastfeeding is influenced by the repercussions of delivery room routines and a challenging learning process where complications often arise, contradicting the prevailing innatist discourse of maternal instinct. Within this framework, mothers feel pressured by professionals to breastfeed, and their identities are undermined by symbolic stigma when they express their decision not to breastfeed. We conclude that it is essential to propose clinical approaches and support models that genuinely consider the sociocultural, historical, and experiential factors influencing breastfeeding, moving beyond an exclusive focus on its biological or nutritional aspects.

Keywords: breastfeeding; women; care; institutional control; social stigma; sociology of deviance; biopower



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1. Introduction

The World Health Organization (WHO) and the United Nations International Children's Emergency Fund (UNICEF) have, for decades, promoted breastfeeding as the optimal method of infant feeding (World Health Organization and United Nations International Children's Emergency Fund 1990, 1991). This advocacy is grounded in extensive scientific evidence pointing to substantial health benefits for both mothers and infants, including a reduced incidence of infections, lower risk of chronic diseases, and improved long-term health outcomes (World Health Organization 2003, 2013). As such, breastfeeding is positioned as a global public health priority, with national and international strategies encouraging its initiation and continuation (World Health Organization and United Nations International Children's Emergency Fund 1990; World Health Organization 2015).

Despite these efforts and broad scientific consensus, breastfeeding practices remain complex and are shaped by a myriad of sociocultural, historical, and individual factors. The predominant biomedical framework that guides much of the promotional discourse

often overlooks the lived experiences of mothers and the diverse contexts in which infant feeding decisions are made (Smith 2014). This misalignment can generate tension between institutional expectations and women's realities—particularly when these realities diverge from the idealised image of motherhood and breastfeeding. In this context, the decision not to breastfeed, or to cease breastfeeding, may be construed as a form of non-compliance or deviance from normative expectations, yet it remains a phenomenon rarely explored from the mother's perspective within academic discourse.

Classical sociological approaches to deviance, such as those proposed by Émile Durkheim, have examined how transgressions from social norms contribute to mechanisms of control and cohesion (Durkheim [1893] 1964, [1895] 1982). Subsequent theorists, including Erving Goffman (1963), have focused on the micro-level consequences of deviance, particularly the management of “spoiled identities” in individuals whose actions or attributes are socially discredited. Within the field of medical sociology, extensive work has examined how diagnoses and health-related behaviours are moralised and subjected to social regulation (Conrad 1992; Zola 1972). Michel Foucault's (1978, 2003) concept of biopower further illuminates the ways in which modern institutions—including hospitals and health systems—govern bodies and populations through the regulation of reproductive and parental behaviours. Rather than relying solely on overt repression, this form of power operates through practices, discourses, and institutional routines aimed at shaping “life itself”. Within this framework, institutional control refers to the often subtle, yet pervasive, mechanisms through which clinical settings guide and normalise particular maternal behaviours. These mechanisms may, in turn, contribute to the symbolic stigma experienced by women whose actions diverge from institutional expectations (Goffman 1963).

When applied to breastfeeding, these theoretical frameworks reveal how the strong institutional promotion of breastfeeding may constitute a form of biopolitical governance. Women who do not align with these expectations—either due to personal choice or physical or emotional difficulties—may encounter social pressure and symbolic sanctions, often expressed through guilt, shame, or perceived maternal inadequacy. While a substantial body of research highlights the benefits of breastfeeding and interventions to improve its uptake, far less is known about the subjective experiences of mothers who choose not to breastfeed or who discontinue breastfeeding shortly after birth. This study seeks to address that imbalance.

Although breastfeeding has been widely studied within biomedical and public health domains, the sociocultural and experiential dimensions of refusal or cessation remain comparatively under-researched. Existing scholarship has examined the stigma surrounding non-breastfeeding mothers (Bresnahan et al. 2020; Murphy 1999), the moralisation of infant feeding (Koerber 2006), and the normative pressures embedded within discourses of “intensive motherhood” (Faircloth 2021). Further studies have explored how breastfeeding advocacy can become coercive when institutional priorities eclipse women's embodied experiences and emotional wellbeing (McFadden et al. 2006; Alianmoghaddam et al. 2017). However, much of this work is situated in Anglo-American contexts and seldom draws on theoretical approaches such as the sociology of deviance or biopolitics to interrogate breastfeeding refusal as a socially regulated phenomenon. In the Spanish context, although the public health literature has documented breastfeeding prevalence and its determinants, sociological perspectives on institutional infant feeding practices—particularly from the standpoint of mothers—remain limited. This article seeks to contribute to this emerging area by applying classical and contemporary sociological theory to investigate how institutional power, symbolic stigma, and maternal agency interact in the context of breastfeeding cessation within hospital environments.

In light of the theoretical perspectives and empirical gaps discussed above, this article aims to explore, from the perspective of the sociology of deviance, the maternal experiences of women who choose not to breastfeed or cease breastfeeding within the hospital setting in Spain. Specifically, it analyses how institutional control, biopower, and symbolic stigma shape these experiences. By examining these women's narratives, we seek to illuminate the complexities of their decisions and circumstances, providing insights that can inform more nuanced and woman-centred approaches to maternity care and infant feeding support.

2. Materials and Methods

A qualitative methodology and a phenomenological design were employed to gather the "emic" perspective of mothers who had chosen not to breastfeed or had discontinued breastfeeding within the context of institutional clinical dynamics.

2.1. Study Context

This study was conducted in the Murcian municipality of Lorca (Spain), a city with a population of 98,447 inhabitants in 2023, of whom 47,921 are women, with 22,327 of these being of childbearing age ([Regional Statistics Center of Murcia \(CREM\) \(2023\)](#)). It is the second Spanish municipality, after Melilla, with the second highest number of children per woman, at 1.61, compared to the national average of 1.24 ([National Institute of Statistics \(INE\) \(2022\)](#)). The average number of births per year is between 1500 and 1600, with an average of 65% of births to national women and 35% to foreign women. The high fertility rate and the high average number of children per woman make the municipality a suitable context for a study focused on breastfeeding.

With regard to the breastfeeding prevalence in this context, data from 2020 provided by the Murcian Health Service indicate an initiation rate of approximately 75%, and an exclusive breastfeeding rate of 32.4% at six months in the Region of Murcia. Although specific data for the municipality of Lorca are limited, these regional figures offer a broader contextual framework for understanding local infant feeding practices. Furthermore, the population of women of childbearing age in Lorca is notably diverse in terms of nationality, with 15.42% being immigrants, the majority of whom are of Moroccan origin ([Regional Statistics Center of Murcia \(CREM\) \(2020\)](#)). These demographic characteristics highlight the complex sociocultural landscape shaping maternal decisions and experiences related to infant feeding.

The hospital where this study was conducted is in the process of implementing the Baby-Friendly Hospital Initiative (BFHI), a programme launched by the World Health Organization and UNICEF aimed at promoting, protecting, and supporting exclusive breastfeeding from birth. The BFHI recommends achieving exclusive breastfeeding by the time of hospital discharge, typically within the first 48 h postpartum. Key practices encouraged by the initiative include avoiding the use of formula feeding bottles and pacifiers, promoting immediate skin-to-skin contact, initiating breastfeeding early, and providing comprehensive training for healthcare staff to support mothers ([World Health Organization and United Nations International Children's Emergency Fund 2018](#)). Furthermore, within the healthcare area to which the hospital belongs, the establishment of exclusive breastfeeding has been adopted as a priority quality indicator, underscoring its importance in maternal and child health care.

2.2. Participants

The study participants were selected using a non-probabilistic, convenience, and snowball sampling technique. The inclusion criteria were as follows:

- Mothers who had expressed the decision not to initiate breastfeeding or had discontinued it during the puerperium. This broad criterion allowed for the exploration of diverse experiences, including both explicit refusal from the outset and cessation due to challenges encountered within the institutional context.
- Mothers with children under five years old at the time of the interviews, to ensure the accuracy of recall regarding their early postpartum experiences.
- Mothers over 18 years old.
- Spanish speakers.

A total of 10 mothers participated in this study (Table 1). We acknowledge that this sample size, typical for in-depth qualitative research, does not allow for statistical generalisation. However, it was chosen to provide rich and diverse insights into the lived experiences of these women, aiming for thematic saturation rather than statistical representativeness.

Table 1. Sample description.

ID	Age	Studies	Marital Status	Children	Nationality	Hospital Care
M1	33	University	Divorced	1	Spanish	Rafael Méndez
M2	38	Secondary	Married	2	Spanish	Rafael Méndez
M3	43	University	Married	2	Spanish	Rafael Méndez
M4	31	Primary	Married	2	Spanish	Rafael Méndez
M5	40	Secondary	Widow	2	Spanish	Rafael Méndez
M6	37	University	Married	3	Spanish	Rafael Méndez
M7	33	University	Divorced	1	Spanish	Rafael Méndez
M8	31	University	Married	1	Spanish	Rafael Méndez
M9	42	University	Married	3	Spanish	Rafael Méndez
M10	38	Primary	Married	2	Spanish	Rafael Méndez

2.3. Data Collection

Semi-structured interviews were used as the primary data collection tool. Interviews were conducted face-to-face and recorded with participants' explicit written consent. All interviews were transcribed verbatim. These interviews took place between March and September 2020. The impetus for this study originated within the framework of a Master's thesis examining the influence of social norms on breastfeeding practices. The interviews were conducted by the student researcher under the close supervision of her academic supervisor, who has extensive experience in qualitative methodologies and maternal health. Although neither researcher was a mother, they shared a cultural background similar to that of many participants, which contributed to fostering an empathetic and respectful interview environment.

The interview guide included broad questions designed to encourage participants to recount their experiences with breastfeeding, their perceptions of institutional support, and factors influencing their feeding decisions. These questions aimed to elicit in-depth narratives without inducing responses, ensuring the capture of the "emic" perspective. Interviews lasted approximately 45–60 min.

In addition to the interviews, the researchers also gathered documentary data related to institutional practices. These included the review of hospital protocols concerning breastfeeding, as well as regional quality indicators associated with exclusive breastfeeding in the healthcare area where this study was conducted. This complementary material provided contextual insight into the institutional frameworks that shape and inform maternal feeding experiences.

2.4. Analysis

The collected data underwent thematic analysis following [Braun and Clarke's \(2006\)](#) six-phase method, which emphasises identifying, analysing, and reporting patterns (themes) within the data. Atlas.ti 8.4 software was used to manage and organise the qualitative data.

The analytical process involved several stages. The initial readings of the transcripts allowed for immersion in the data. Subsequently, codes were generated to identify meaningful units of text. These codes were then grouped into broader themes and subthemes, reflecting recurrent patterns and conceptual insights. While the software facilitated the organisation and frequency counting of codes, the interpretation and thematic construction were driven by a rigorous iterative process of researcher reflection and theoretical engagement with concepts such as biopower, institutional control, and stigma. This approach ensured that the analysis moved beyond the mere word frequency to capture the nuanced meanings and lived experiences expressed by participants, seeking specific theoretical connections rather than relying on neutral observation of instances.

2.5. Ethical Considerations

All participants provided their written informed consent prior to participation, ensuring their voluntary involvement and understanding of this study's purpose. Anonymity and confidentiality were maintained throughout the research process, with all identifying information removed from transcripts and pseudonyms used for participants.

2.6. Limitations

This study, while providing rich qualitative insight, has certain limitations. The non-probabilistic sampling method and the sample size of 10 participants mean that the findings are not statistically generalisable to the broader population of women in Spain. However, they do offer an in-depth understanding of specific experiences. Additionally, reliance on retrospective accounts (with children under five years old) may introduce recall bias, though efforts were made to focus on salient and impactful early postpartum memories. Our study primarily captures the perspectives of mothers; future research could benefit from incorporating the viewpoints of clinical staff involved in breastfeeding support. This study's focus on the experiences of women in a specific Spanish municipality, while providing valuable contextual depth, may limit its direct transferability to other cultural or healthcare settings. This study did not explore the intersection of breastfeeding decisions with the women's return to work, which is a relevant factor for many mothers, but was outside the scope of our primary research questions which focused on the immediate postpartum hospital experience and early decisions.

3. Results and Discussion

Mothers' experiences regarding breastfeeding, particularly when diverging from prevailing norms, reveal complex dynamics of institutional control, biopower, and symbolic stigma. Our findings highlight how women navigate intense pressures to breastfeed, often facing significant challenges that can lead to a conscious decision not to initiate breastfeeding or to discontinue breastfeeding despite initial attempts. This section delves into these multifaceted experiences, demonstrating the tension between idealised concepts of maternal instinct and the lived realities of postpartum care.

3.1. Surviving Motherhood: The Postpartum Body and Emotional Burden

The postpartum period is often depicted as a time of immense joy; however, for many mothers, it is accompanied by profound physical and emotional challenges that are

frequently overlooked in dominant discourses. Our interviews revealed that the period immediately following childbirth is often characterised by significant physical discomfort, pain, and exhaustion, which profoundly impact a woman's capacity and desire to breastfeed. Participants described how the physical toll of childbirth, including stitches, perineal pain, and recovery from C-sections, made the act of positioning the baby and maintaining lactation physically arduous.

As M-1 recounted, "He immediately cried...I did not feed him...I don't know, I did what I could" (M-1). This sentiment was shared by M-3, who struggled with milk production: "He was hungry, like me the milk...it was more like water, I gave him the breast and then I had to prepare a bottle for him" (M-3). These narratives underscore that for many women, the decision not to breastfeed or to cease breastfeeding is not a simple "refusal," but rather a pragmatic response to overwhelming physical and emotional realities. As M-10 indicated regarding her childbirth experience: "She put her hand in me without warning me and I felt as if she was tearing me, she told me: 'Let's see, open up' and she did it this way but fast (she simulates pulling with her hand) and she pulled as if they were tearing out my entrails" (M-10). Similarly, M-9 recounted persistent pain: "I was in pain and it bothered me even to speak, imagine to sit up (...). In addition, after eight days my stitches were opened (cesarean section) and I had a terrible time" (M-9). Beyond direct physical pain, recovery was complicated by other discomforts: "They gave me the 'afterpains' ... what pain by God! I was telling my sister; Carmen that another one is coming!... they didn't want to give me pills for the pain" (M-5). This discomfort was not limited to the hospital: "I was in a wheelchair because of the stitches... terrible! (...) and they sent me home only with 'enantyum', I took a shower and milk started to come out, each time with pain... I decided to give her a bottle and after three days it went away by itself" (M-4).

The ubiquitous discourse of maternal instinct often fails to acknowledge these postpartum realities, instead promoting an idealised, almost effortless, breastfeeding experience (Odent 2007; Kitzinger 2003; Hrdy 2011). This disconnect between the idealised narrative and lived experience can lead to feelings of inadequacy and failure when difficulties arise. Furthermore, the emotional burden of new motherhood, including sleep deprivation, hormonal changes, and the immense responsibility of caring for a newborn, significantly impacts mental well-being, which is often crucial for successful breastfeeding. When these challenges are compounded by a lack of adequate support or a perceived failure to meet societal expectations, mothers may find themselves in a position where discontinuing breastfeeding becomes a necessary act of self-preservation. The institutional focus on breastfeeding rates can inadvertently create an environment where women's physical and emotional recovery takes a backseat, contributing to their distress and ultimately to their decision to opt for alternative feeding methods.

3.2. *The Biopolitical Body and Institutional Control*

The promotion of breastfeeding in hospitals is deeply embedded within a biopolitical framework where the female body is a site of intervention and regulation. Building on the empirical evidence of these physiological changes, certain ideologues of motherhood have promoted a whole series of naturist and ecofeminist theorists, who interpret scientific findings through specific philosophical lenses to fiercely defend maternal instinct. This strong advocacy, while based on health benefits, can transform into a form of institutional pressure that minimises individual agency.

The hospital environment, with its routines, protocols, and the constant presence of healthcare professionals, exerts a powerful form of institutional control. Mothers reported feeling under constant surveillance and pressure to breastfeed, even when facing difficulties.

As M-5 described, *“They came every hour, asking if I had breastfed him. I felt like I was failing them, not just my baby”* (M-5). This pervasive pressure, framed as support, can paradoxically disempower mothers by eroding their sense of autonomy over their own bodies and choices.

The concept of biopower (Foucault 1978, 2003) is particularly relevant here, as it illustrates how institutions manage and optimise the population’s “life” by shaping individual behaviours, ostensibly for their own good. Breastfeeding, in this context, becomes a regulated behaviour, a public health goal that individual mothers are expected to fulfil. *“Yes. . . I used to pump my colostrum because Valeria did not latch on, because I don’t know what was wrong, she could not suckle, she did not latch on well, neither of us could do it”* (M-7). *“I tried, but I didn’t get the rise correctly. . . and I had to supplement the baby with a bottle. . .”* (M-2). *“Man, it’s not like they suck a teat and then nothing comes out. . . I just didn’t get the rise. . . I left the hospital feeling bad, with a bad feeling”* (M-5). *“I didn’t get a rise and when I sucked on them it was an annoying feeling because nothing came out”* (M-9). The experience of pain was also crucial: *“But. . . terrible! . . . the skin. . . terrible! No matter how much cream I put on. . . cracks already bloody, blood (. . .) come on, come on! (. . .) 13 days with a crack. . . terrible, terrible! Crying”* (M-2). And, anatomical difficulties were present: *“What happened is that I don’t have a nipple and, of course, it was more difficult that way, and when I sucked on them it was an annoying sensation because nothing came out of there”* (M-9).

In this biopolitical system, the notion of “autonomy” takes on a complex meaning. While bioethics often emphasises the mother’s right to free and uncoerced decision making, our findings suggest that this right is often compromised within institutional settings. Participants frequently felt their choices were not genuinely respected when they deviated from the pro-breastfeeding script. Their narratives suggest that what appears to be a personal choice is, in fact, strongly circumscribed by institutional expectations and the broader biopolitical agenda. This challenges the simplistic application of autonomy in a context where the body and its functions are subject to intense medical and social governance.

3.3. Symbolic Stigma and Deviance

When mothers choose not to breastfeed or cease breastfeeding, they often experience powerful symbolic stigma, consistent with Goffman’s (1963) concept of a “spoiled identity”. This stigma arises from diverging from the highly valued social norm of breastfeeding, transforming their personal feeding choice into a public marker of perceived inadequacy or “deviance”.

The collected narratives reveal various manifestations of this stigma. M-7 shared, *“I felt like less of a mother because I couldn’t breastfeed. The nurses looked at me differently”* (M-7). This sentiment aligns with empirical work on stigma in non-breastfeeding mothers (Bresnahan et al. 2020). The institutional promotion of breastfeeding, while well-intentioned, can inadvertently contribute to this stigmatisation by creating a normative framework where alternatives are implicitly devalued. The notion that “breast is best” (Murphy 1999) can translate into “formula is bad,” imposing a moral judgment on mothers who choose formula feeding. *“No, the only thing was to insist on putting the baby on my breast, they even told me that I didn’t know how to put it on and that’s why I didn’t get anything out of it. . . I didn’t want to put it on, but they forced me and I had to attach it to my breast”* (M-5). The pressure to conform was evident: *“I had to get a little bit strong, well. . . not to lose my manners, my nerves or anything like that, but to say; please, they are not saying no. . . to try, to try, but all of them. . . In that conflict. . . I don’t know, it probably lasted the three days there. . . the three days there were a conflict”* (M-2), even when making a firm decision: *“My family was not given the bottle, so when I was able to get out of bed, I went to the control room and explained that I was the one who had given birth and I am the one who makes the decisions”* (M-3). The response to the decision not to breastfeed could be judgmental: *“Yes, they gave it to me, the last day, already dressed, I said; give me the pill*

(she laughs). I had to insist a lot [...] besides, one of them came to me and said; you have a mental trauma!... they gave it to me in a bad way" (M-2).

This experience of stigma is not merely internal; it is often reinforced by interactions with healthcare professionals and family members. Participants recounted instances where they felt judged, criticised, or misunderstood when explaining their difficulties or decisions. The pressure to conform to the breastfeeding ideal, even when physically or emotionally unfeasible, highlights how individual bodies and choices become sites for the enactment of social control and the production of deviance.

This is particularly evident in the hospital where this study was conducted, where healthcare professionals themselves are subject to considerable institutional pressure to promote and ensure exclusive breastfeeding by the time of discharge. This pressure is operationalised through a series of structured protocols that accompany mothers throughout the childbirth and postnatal care pathway. These include the systematic implementation of immediate skin-to-skin contact following both vaginal and caesarean births, the presence of a dedicated midwife on the postnatal ward whose primary responsibility is to ensure that mothers establish exclusive breastfeeding, and a specific midwife-led consultation aimed at supporting and sustaining breastfeeding after discharge.

While such practices are ostensibly designed to support maternal and infant health, the imperative to meet the targets set by the Baby-Friendly Hospital Initiative frequently transforms these supportive measures into mechanisms of coercion, exerting normative pressure on mothers to comply with institutionalised ideals of maternal conduct.

The resistance encountered by mothers in these contexts ([Alianmoghaddam et al. 2017](#)) further underscores the disciplinary power of medical discourse and institutional expectations ([Koerber 2006](#)), illustrating how healthcare settings can become sites where maternal agency is constrained in the name of public health ([Hausman 2003](#)).

Despite pressure to breastfeed, a lack of real support from professionals was evident: "They gave me the breast pump and told me to do that and nothing else. No one came to see if the girls were latching on well or not, or to tell me how to do it. I told them I didn't have a nipple and they gave me the breast pump and that was it" (M-9).

3.4. Addressing the Conflict: Beyond the Instinct Narrative

The emphasis on a biological "maternal instinct" to breastfeed, while seemingly natural, often overlooks the complex interplay of physiological, psychological, and social factors that truly shape a woman's feeding journey. This idealised narrative, often perpetuated in clinical settings, can create significant distress when mothers face genuine difficulties or make alternative decisions. Our findings strongly suggest that for many participants, the decision not to breastfeed or to discontinue was a pragmatic, often painful, adaptation to circumstances that contradicted the "instinct" narrative. "It gave me feelings, but at the same time I didn't feel good... it was an accumulation of mixed feelings (laughs), I felt sorry to stop breastfeeding [...] but, of course, psychologically I couldn't... I just felt like crying (laughs)" (M-1). "I tried, hey, I tried... it has always been said that natural breastfeeding is better than bottle feeding... I tried... but no... what do I do, what do I do, what do I do (feeling of guilt)" (M-2). This highlights how the body and its practices become sites of "deviant" embodiment when they do not conform to societal ideals, as explored in the broader literature ([Young 2020](#)).

Prevailing biomedical discourses, therefore, are not only shaped by scientific evidence, but also respond to sociocultural traditions and models of medical practice, which function as rigid norms within clinical institutions. This creates a tension between the idealised norms of intensive motherhood, often linking maternal devotion with breastfeeding, and women's lived experiences, particularly in the context of institutional pressure ([Faircloth 2021](#)). A lack of support and the focus on exclusive breastfeeding can lead to complications

for the baby, for which mothers blame the system: *“The baby lost about 600 g and in the afternoon he became jaundiced due to the degree of dehydration the baby had, they had to take him to the incubator...they were symptoms of dehydration...then they would help him with the bottle”* (M-6). *“The baby lost a kilo and a half...then I asked (the pediatrician): What’s going on? because the baby has lost a kilo and a half and then we went out with a bag of bottles...if I had known: I would have raised the hospital! and they would have had to give me a bottle because my daughter had hunger”* (M-5). These feelings of guilt and discomfort persisted over time: *“I left with my withdrawal pill taken, maybe I didn’t try hard enough, hey, I blame myself for that part, yeah”* (M-2). *“Well...they made me feel bad about breastfeeding...I just wanted to give him a bottle at night...I did what I could”* (M-10).

4. Conclusions

The present study has explored the complex experiences of women in Spain who, within the context of hospital dynamics, chose not to breastfeed or discontinued breastfeeding. Our findings underscore that these decisions are not merely individual choices, but are deeply shaped by institutional controls, the exercise of biopower, and the omnipresent symbolic stigma within the healthcare system. The idealised and innatist discourse surrounding maternal instinct often clashes with the challenging realities of postpartum recovery and the difficulties many mothers face, leading to feelings of inadequacy and perceived failure when they cannot conform to established norms.

We have demonstrated that, far from being simply a personal preference, the decision not to breastfeed or to cease breastfeeding can result in mothers feeling labelled or judged as deviant within a system that rigorously promotes exclusive breastfeeding. While our study did not identify explicit punitive measures, the subtle and implicit pressures, combined with the idealisation of breastfeeding, create an environment where non-conformity can lead to significant emotional distress and social marginalisation. This highlights the need for a more empathetic and nuanced understanding of diverse infant feeding paths.

Importantly, these findings must be situated within the specific cultural and institutional context of this study. The region of Murcia, and particularly the city of Lorca, presents relatively high rates of breastfeeding initiation compared to other countries in the Global North—approximately 75% at hospital discharge and 35% at six months. In this context, where breastfeeding is not only medically encouraged, but also widely socially valorised, deviation from this norm may carry a particularly heavy symbolic weight. The institutional implementation of the Baby-Friendly Hospital Initiative and the designation of exclusive breastfeeding as a quality indicator reinforce this normative expectation. Thus, the experiences of stigma and emotional burden reported by participants must be understood within this highly pro-breastfeeding local environment, which differs significantly from other Western settings, such as the United Kingdom, where exclusive breastfeeding rates at six months remain considerably lower.

In conclusion, it is imperative to move beyond a narrow biomedical or purely nutritional emphasis on breastfeeding and adopt a broader sociocultural approach to maternity care. This requires the development of clinical and support models that genuinely consider the multifaceted realities of mothers, integrating their individual histories, sociocultural contexts, and lived experiences into the care framework. Such models must foster an environment of genuine autonomy and support, recognising that a woman’s decision regarding infant feeding is influenced by a complex set of factors that extend far beyond biological imperatives. By adopting a more holistic perspective, healthcare professionals can better support all mothers, regardless of their feeding choices, and mitigate the symbolic stigma often associated with deviating from institutional norms.

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Informed Consent Statement: Informed consent was obtained from all subjects involved in the study.

Data Availability Statement: The raw data used during the field work are available under specific author requirement.

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