

REVIEW ARTICLE

Breastfeeding as the New Cultural Taboo

Tomori, Cecilia. 2014. *Nighttime Breastfeeding. An American Cultural Dilemma*. New York, Oxford: Berghahn Books. 299 pp. Hb.: \$110.00 / £68.00. ISBN: 9781782384359.

Wolf, Joan. 2011. *Is Breast Best? Taking on the Breastfeeding Experts and the New High Stakes of Motherhood*. New York: New York University Press. Kindle Edition. ISBN: 9780814795255.

In this essay, two books about the current debate on breastfeeding are discussed. *Is Breast Best?* presents one of the rare voices that have challenged the current breastfeeding orthodoxy, which contends that breastfeeding is a superior form of infant feeding and assumes that virtually all properly informed mothers want to and should breastfeed their children. In contrast, Tomori's book represents this mainstream position and contains much explicit advocacy for systemic changes in support of breastfeeding. Tomori criticises Wolf and other feminist authors who are against breastfeeding advocacy (Tomori 2015: 83). Tomori is a modern Marxist, while Wolf draws on a modification of Beck's "risk society" paradigm. Wolf's approach is more theoretical, while Tomori's work is a classic ethnography based on fieldwork. Comparison of these different approaches provides insight into macro-level academic debates and micro-level dilemmas of everyday life. Both authors focus on the American context of breastfeeding. However, they are relevant beyond American borders because the US serves as a kind of a global trend-setter and a principal promoter of breastfeeding, along with international organisations who put pressure on women worldwide to breastfeed.

Ethnography of night time breastfeeding

Tomori's *Nighttime Breastfeeding* explores current trends in sleeping/breastfeeding practice during infant's first year in the USA. Tomori conducted an ethnographic study of night time breastfeeding practice among middle-class parents (18 mothers and 15 partners) in a Midwestern US city during 2006, 2008, and 2009. Tomori argues that nighttime breastfeeding dilemmas 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 ...' (Tomori 2015: 3).

Tomori discusses moral dilemmas of breastfeeding (and co-sleeping), and the "production" of parenthood through decisions on night time breastfeeding (Tomori 2015). Her approach is imbued with a Marxist "social class reproduction" perspective, with corresponding terminology ("biocapitalism", "capitalist medicine", "capitalist temporal regimes") (Tomori 2015: 168). She argues that only the middle or upper-middle classes can provide resources (financial resources, information) for pursuing longer breastfeeding practice. A father's support for breastfeeding is defined as a generator of class reproduction (Tomori 2015: 168). However, Tomori's position on breastfeeding and capitalism is

ambivalent. On the one hand, she believes that capitalism is hostile to breastfeeding and uses F. Dykes's metaphor of supply-demand in breastfeeding to argue that it reflects the capitalist oppression of women who should meet "production quotas" (Tomori 2015: 39). On the other, Tomori believes that capitalism has commercialised infant feeding, either through formula marketing and "technoscientific innovations", or through now popular commercial wet-nursing (Tomori 2015: 45). Either way, according to Tomori, capitalism is anti-breastfeeding oriented, even though the strongest breastfeeding lobbies is found in "capitalist countries".

Tomori argues that, unlike breastfeeding, which has public and medical support, there is no clear model for infant sleeping (Tomori 2015). American parents are, therefore, caught between at least two models: Ferber's model of solitary sleep with infant feeding on schedule, and Sears "attachment parenting" which promotes breastfeeding on demand and co-sleeping (Tomori 2015: 77). Different approaches to sleep are related to different philosophies of children's personhood: sleeping alone is seen as a way to help a child acquire independence while constant nurturance of co-sleeping encourages a sense of security (Tomori 2015: 203). Furthermore, there is a debate about safety issues of co-sleeping (Sudden Infant Death Syndrome) and the American Academy of Pediatrics (AAP) currently recommends co-sleeping if certain conditions are met (no drugs and alcohol use) (Tomori 2015: 134). Finally, infant sleeping practices are inseparable from cultural taboos about sexuality and incest (Tomori 2015: 139). There is a stigma related to bed sharing. To avoid this stigma, parents are reluctant to report it to health care providers (co-sleeping doubled 1993-2000) (Tomori 2015: 139, 70).

Total motherhood in a risk culture

Breastfeeding is intrinsically linked to a dominant motherhood model in a given cultural context. Tomori and Wolf agree that breastfeeding is inseparable from the concept of "good motherhood". However, motherhood models and breastfeeding standards have changed over time (Tomori 2015). "Sacred motherhood" was rooted in a religious concept of the moral and spiritual duty to breastfeed. This concept was never fully embraced; wealthier women, in particular, were not so willing to breastfeed their children (Tomori 2015: 57).

"Scientific motherhood" originated in the mid-19th century. It laid foundations for the medicalisation of child-care as it was based on a scientific approach to child care practices, regular infant measurements, constant monitoring and time schedules (Tomori 2015: 58). This 'scientific management model for mothering' included the idea of uninterrupted baby sleep and nursery rooms with adequate equipment (such as cribs) that would, from an early age, create a clear separation between the child and its parents (Tomori 2015: 59). Infant formula was initially a part of scientifically controlled infant feeding that:

offered a modern, scientific, and rational method of feeding babies ... With formula, which was produced under scientific, hygienic circumstances, there would be no more worries about the transfer of disease, alcohol, and lower-class or immigrant moral qualities to the child (Tomori 2015: 59).

Once again, the pendulum had swung towards the opposite extreme. An early stage in this change was La Leche League's mid-fifties advocacy for the revival of sacred motherhood, with a slight modification towards "natural motherhood" (Tomori 2015: 62). The "natural" was combined with scientific rigor, research evidence, and official directives by public health authorities (Tomori 2015). This cultural shift is compatible with the New Age return to the organic, the earthy, the genuine and the primordial, based on a "scientific" belief that health and longevity can be controlled directly by proper lifestyle choices. This mind set has formed the basis of "new parenthood" and brought new methods of giving birth, infant holding, changing, feeding, and sleeping, supported by some or no scientific evidence.

According to Tomori, the key characteristic of modern good motherhood is sacrifice. One mother from Tomori's research says that she tried to encourage herself to follow through with pediatrician's advice, even though it was very difficult, by consulting the heuristic: 'if it's more difficult it must be better' (Tomori 2015: 132). Breastfeeding has now assumed the status of moral imperative, indivisible from the conception of good mothering: 'While ideologies of sacrifice are part of discourses of "good motherhood, mothers" negative experiences disrupted idealised images of mothers who joyfully breastfeed despite encountering obstacles' (Tomori 2015: 122). Tomori's respondents were reluctant to admit difficulties in breastfeeding, as if they feared stigmatisation of this socially unacceptable experience. The other side of the coin is an emotional burden: self-blame for not being able to feed baby properly, despite family support (Tomori 2015: 122). Tomori admits that 'parenting ideologies that fully embrace breastfeeding – in mandating the specific form of breastfeeding practices – could be morally oppressive...' (Tomori 2015: 140).

Wolf's interpretation of the modern history of motherhood is similar. The central concept is "total motherhood", which gradually emerged from the foundations of domesticity (a notion that women's primary role is in raising children and maintaining home) and scientific motherhood (an idea that women must be educated by experts in order to properly raise children) and often supplemented by natural mothering (the idea that mothers are uniquely capable of recreating safer, simpler environment that is in fact ideal for their babies). Domesticity is central to total motherhood as it puts the responsibility to optimise the child's life through scientific planning almost exclusively on mothers – fathers, the broader family and social networks and institutions are largely absolved of such obligations. Both of these earlier developments, as well as total motherhood, were almost exclusively middle-class projects and excluded the majority of the female population in their creation (Wolf 2011: 72).

Total motherhood stipulates that mothers' primary occupation is to predict and prevent all less-than-optimal social, emotional, cognitive, and physical outcomes; that mothers are responsible for anticipating and eradicating every imaginable risk to their children, regardless of the degree or severity of the risk or what the trade-offs might be; and that any potential diminution in harm to children trumps all other considerations in risk analysis as long as mothers can achieve the reduction. (Wolf 2011:72)

The initiation into total motherhood begins before babies are conceived, with the not too subtle expectation that it is the future mothers' duty to adequately prepare their bodies for the optimal growth of their not yet (and perhaps never existent) children. In the US, women are advised to get "preconception care", e.g. take supplements, observe nebulous "healthy eating" norms, chart their fertility etc., by major national institutions and popular books and sites (Wolf 2011: 75–6). The pressure is then increased manifold as pregnancy commences. Women are warned that their pregnancy diets will impact the long-term health of their babies through "fetal programming" (Wolf 2011: 80). The unofficial pregnancy bible, *What to Expect When You're Expecting*, advises that the not-yet-born baby's supposed needs must determine every bite the woman takes:

Every bite counts. You've got nine months of meals and snacks with which to give your baby the best possible start in life. Try to make them count. As you raise fork to mouth, consider, 'Is this a bite that will benefit my baby?' If it is, chew away. If it isn't, see if you can't find a bite more worthy (Cited in: Wolf 2011: 78).

As in scientific studies of breastfeeding, the evidence does not come anywhere close to supporting the moral norms that now surround pregnancy; for example, even small amounts of alcohol consumed during pregnancy are considered risky, while studies have shown that 'only about 5 percent of women who drink heavily give birth to babies exhibiting signs of FAS, and "there is no consistent, reliable evidence [...] to indicate that alcohol categorically affects fetal development regardless of the level of exposure or timing of exposure, or absent other factors"' (Cited in: Wolf 2011: 81).

The new motherhood is trying to combine the natural and the scientific, hence its contradictions: there is a permanent conflict between 'being natural' and 'being scientific', but both are based on the general ideology of risk avoidance. Paradoxically, the ideology of risk prevention is risky, because decisions about breastfeeding have to be made in the context of limited and rapidly changing information where risky choice can easily become a next safe choice. Tomori comments that all breastfeeding decisions are placed in a climate of 'moral minefield' (Murphy, as cited in Tomori 2015: 120). Breastfeeding triggers many moral aspects, and it imposes costs, i.e. moral risks, for those who do not breastfeed, but also for those who do: 'in this "moral minefield", there are no "winners"' (Tomori 2015: 136). For example, one conflict is between the new cultural model of "highly engaged paternal persona", which has to be negotiated with the still valid "breadwinner fatherhood". Another dilemma is about co-sleeping and solitary sleeping practice, as discussed above.

Natural mothering adds another twist to the ever more demanding role of a mother in encouraging women to shun modern conveniences (e.g. disposable diapers, canned food, manufactured clothing and formula) in order to minimise risks to their babies. Once again, the inherent trade-offs of such choices, and in particular the time and effort such norms put on mothers are rarely explicitly entertained. As children are born, they become a new and ever expanding source of information to mothers and medical professional in respect to the optimality of their development. Through pediatricians' vis-

its, government campaigns and informal networks, mothers are inundated with the “best and latest” information on what else they can do to protect and support their children and properly fulfill their roles as mothers.

In order to explain the recent changes in breastfeeding practices and total motherhood, Joan Wolf has developed the concept of “risk culture” (Wolf 2011: 52), based on Beck’s concept of risk society (Beck 1992). However, there are differences between the two concepts: whereas Beck is focused on what he considers to be actual, uncontrollable, global risks (for example, nuclear or environmental risks), Wolf is focused on individual efforts to minimise risks, real and imagined, at all costs, and an emerging moral imperative to do so. According to Beck, individuals are destined to live with many uncontrollable risks, whereas Wolf believes that modern individuals generally believe in controlling or at least minimising the risks (Beck 1992; Wolf 2011).

Wolf’s risk culture is a pattern of collective overreliance on quantified risk assessments and apparently scientific evidence in charting one’s life course. In risk culture, lifestyle choices that were previously considered inconsequential are increasingly measured, analysed and compared regarding the risks they pose, especially in regard to health. Since the general public has neither the methodological nor the substantive background to evaluate evidence that purports to show that some lifestyle choices are to be avoided, it essentially relies on second-, third- or fourth- person accounts on what scientific evidence shows, by people such as journalists, popular experts, bloggers or celebrities who are often in not much better position to evaluate them. Within the current risk culture and its plethora of apparently scientific advice and data, a belief that life can be optimised and misfortunes largely avoided through proper behaviour is increasingly common. Therefore, mothers are becoming the main culprit lest anything bad or even less than optimal befalls their children.

Science in the service of a dogma

Science has had a profound effect on breastfeeding attitudes. An important part of the scientific approach to parenting (“scientific motherhood”) was a growing accumulation of evidence about the differences between breastfed and formula-fed infants (Tomori 2015: 64). This evidence attracted other key creators of public health policies to La Leche League’s position: the World Health Organization, UNICEF, the US government, and recently even Michelle Obama (Tomori 2015). Since the 1990s, in new declarations and public health recommendations, formula feeding is no longer considered acceptable as an alternative to infant feeding. Obviously, an important question is whether the scientific evidence truly does give sufficient reason to believe that breastfeeding is substantially better than formula milk.

The two authors do not share the view on science and breastfeeding. Tomori believes in scientific evidence regarding benefits of breastfeeding and also the evidence-based public policies for breastfeeding promotion. This is evident in her expressed worry that, in spite of all efforts, there are still a few “infidels” (one third of them in one public opinion survey) who are prone to believe that formula is as good as mother’s milk (Tomori 2015: 66). As she says, ‘my own reading leaves me quite convinced of the sub-

stantial health consequences of not breastfeeding' (Tomori 2015: 83). Moreover, Tomori advocates for more participation of anthropologists in public health initiatives (Tomori 2015: 241).

Wolf, in contrast, challenges the medical orthodoxy that is used to support both risk-averse culture and total motherhood. Thus far, many studies have attempted to demonstrate the benefits of breastfeeding on infants' health and development and women's health (cf. Quigley, 2012, Beral, 2002). However, the empirical evidence in support of breastfeeding benefits is much weaker than usually assumed. Statistical associations between breastfeeding and various health outcomes in infants (obesity, GTI infections, otitis media infections, diabetes, respiratory infections, cognitive ability, asthma, allergies, leukemia, diarrhea are just some of those studied) are often weak and inconsistent; scientists studying one issue often find weak effects but reinforce the breastfeeding's status by assuming other effects are much stronger (Wolf 2011). In addition, breastfeeding mothers are different from bottle-feeding mothers on a host of variables (e.g. income and education) shown to influence health. Even statistically controlling for these variables leaves the decision to breast feed as a confounding factor; a famous PROBIT study, the largest randomised study of breastfeeding, found, despite measuring plethora of outcomes, breastfeeding to have an effect only on GTI infections and cognitive ability, the latter claim being more suspect (Wolf 2011: 32). Finally, any causal claim for breastfeeding benefits needs, in addition to statistical evidence, a plausible physiological mechanism – all the more so where putative effects of breastfeeding are temporarily far removed from the breastfeeding period. In the case of breastfeeding, however, any physiological understating of the way in which breast milk exerts its effects is severely lacking, except for GTI infections (Wolf 2011: 33). Scientific studies have not shown bottle-feeding to pose anything close to the risk of smoking, to which it is routinely compared.

Not only are many breastfeeding studies poorly designed or otherwise not showing effects anywhere close to those assumed and advertised to the public, the choice of topics themselves also shows a strong pro-breastfeeding bias. For example, several studies have shown that breast milk contains various pollutants, such PCBs, DDT, flame retardants, dioxins, heavy metals, etc., to the point that breastfeeding advocates have admitted that 'if breast milk were regulated in the same way as formula is, it would commonly violate Food and Drug Administration action levels for poisonous or deleterious substances in food and could not be sold.' (Wolf 2011:122). Despite its obvious importance in the context of the widespread and institutionalised exhortation to breastfeed, this kind of research has been discouraged; in words of one prominent breastfeeding advocate: 'When agencies like the E.P.A. decided to monitor the presence of toxins in the environment through breast milk, people like me said, "Please don't do that – it will be misinterpreted."' (Wolf 2011: 122). However, at the same time that these much-needed studies are avoided, dozens of studies are being funded to examine safety of breastfeeding while on medications such as SSRIs (e.g. Hallberg and Sjöblom: 2005) or while suffering from various medical conditions, such as HIV (Dunn et al: 2000).

The role of scientific evidence in risk culture is particularly problematic, because while its methods appear impersonal, the choice of topics, background literature, inde-

pendent and dependent variables reflect not only prevailing scientific paradigms but also broader cultural trends. In addition, statistical techniques involved in establishing effects allow for considerable flexibility by which statistically significant effects are extracted from a massive number of tests, thus leading to manifold increases in false alarms; a rapidly growing body of literature demonstrates just how pervasive this problem is: there is a lively ongoing debate regarding whether less or more than a half of research findings published in medical journals is false (Jager & Leek 2014; Ioannidis 2014). Scientific studies of breastfeeding, with their presumption of breastfeeding superiority and their almost exclusive focus on health benefits for the baby, are by no means immune to this trend.

The emphasis on breastfeeding is putatively driven by scientific evidence of its superiority and in that it presents a culmination of expert-driven, medicalised and quantified culture. The most recent historical wave of breastfeeding enthusiasm was partly driven in response to the expert-driven emphasis on formula. However, as the breastfeeding movement gained steam, it has been incorporated into a long-standing solution of pediatricians' dilemma as to the purpose of their profession as 'baby feeders' (Wolf 2011: 1).

Science and scientists are generally revered as a source of objectivity, but the almost invariably weak effects of lifestyle choices on life outcomes lead to ever-changing and qualifying recommendations, making the aspiration to a risk-minimised life ever harder to satisfy. Nevertheless, some science-supported risk-minimising recommendations do gain public traction. Often they then become an impetus for more studies confirming that recommendation thus creating a positive feedback between science and the public. The result of this process is essentially a moral code rooted in an appearance of scientific certainty but with little actual foundation in the real world.

The new taboo and new dissonant voices

The institutional and cultural pressure on women to breastfeed is overpowering and relentless. The World Health Organization recommends not only exclusive breastfeeding for at least six months but claims that an HIV-positive status is not an obstacle to breastfeeding (WHO 2002; WHO 2010). When women are advised that infant ingestion of breast milk may lead to the possible contraction HIV infection, we have clearly come to the point where breastfeeding has become the new cultural taboo.

Since the 1990s, this pressure has been exerted through an informal coalition for promotion of breastfeeding, consisting of scientists, governments, international organisations, non-governmental organisations, religious organisations, mothers, fathers, and even childless people. In the US, where this pressure is easiest to track and document, it is led by the government and expert bodies such as American Academy of Pediatrics (AAP), popular child-rearing gurus such as Dr. Sears, and women and mothers themselves.

The National Breastfeeding Awareness Campaign (NBAC) conducted throughout the US from June 2004 to April 2006 is an example of this. The campaign was conducted through television, radio and print advertisements, billboards, posters, pamphlets, and websites and, in its final form, after much internal bickering as representatives of formula manufacturers pushed against the most outrageous claims, used, among other things, images of pregnant women log-rolling and mechanical bull-riding with a mes-

sage ‘You’d never take risks while you’re pregnant. Why start when the baby’s born?’ as analogous to formula feeding (Wolf 2011: 109).

These advertisements were meant to provoke anxiety in mothers regarding bottle feeding. To achieve that goal, the benefits of breastfeeding compared to bottle-feeding were greatly exaggerated. Specific risk-ratios that would, at least in principle, allow the public to understand the modest magnitude of breastfeeding effects, were not included for fear of muddling the message. In line with the total motherhood ideology, the perspective of women was ignored, and it was assumed that any benefits to babies justified any cost to the mother. In short, in the US, a major national, government-led breastfeeding campaign proceeded as if breast-milk was an absolute good and no trade-offs were involved: the risk of not breastfeeding was compared to those of activities many orders of magnitude riskier, and the burden was placed on mothers without any consideration of cost or trade-offs it involves.

This collective mind set is influencing science as well. Many clearly important research topics relevant for breastfeeding are not explored. As Wolf said, breastfeeding ‘serves as a repository for numerous cultural anxieties ...’ (Wolf 2011: 137). Child-centred and benefit-oriented research on breastfeeding has created a biased perspective. There is no elaboration of the “cost side”: emotional stress, disturbed sexual relations with spouses, time management, career sacrifices, and physical burden of taking over the household labor so that mothers could focus on around the clock breastfeeding. Even an anthropologist is reluctant to deal with the subject of breasts’ dual nature, i.e. as a sexual and a non-sexual object. Tomori admits that her study design was not made to adequately address the father’s perspective and, in particular, sensitive issues of sexuality and breastfeeding (Tomori 2015: 166). Men’s “kin work” is only analyzed as part of the support needed for breastfeeding practice: ‘Men’s contributions to the breastfeeding relationship can help overcome the lack of structural and cultural support as well as mitigate moral challenges generated by breastfeeding’s embodied praxis’ (Tomori 2015: 166). Tomori has at least acknowledged that the issue of sexual relations between partners after childbirth was not adequately discussed in childbirth education classes (Tomori 2015: 152).

Also, opportunity costs of mother’s time, short-term earning costs and long-term career costs (Rippeyoung et al. 2012) are rarely addressed. The economic side of breastfeeding is studied only with respect to obstacles to breastfeeding. The effects of breastfeeding on parental economic status are much less frequently discussed. Only recently have the costs of breastfeeding from parental point of view (emotional, physical and social) been recognised as a valid research subject (Murphy 1999; Wolf 2011; Forster 2010; Marshall, Godfrey & Renfrew 2007).

As a result of this biased approach, a mechanistic perspective is dominant in research on breastfeeding. It focuses on the external conditions and does not take into account internal factors (for example, the everyday drudgery of breastfeeding, even when mothers breastfeed successfully). For example, Tomori reports that many systemic actions have been taken to promote breastfeeding (for example, lactation breaks at work) and advocates for social policies, “conditions” that should enhance breastfeeding: community mother-to-mother programs, changes in the healthcare system, clinician train-

ing, employer-established paid maternity leave, changes within the family (Tomori 2015: 69, 242). Here, the emphasis is placed on those factors that impede breastfeeding, while women's desire to breastfeed is assumed. None of these policies tackle the emotional and personal costs of breastfeeding, which is not always completely "joyful", even when managed by well-off, educated, and highly devoted, two-parent teams. Another issue is whether systemic changes would actually make a difference. For example, Serbia has a low breastfeeding rate (only 14% of children are breastfed exclusively for six months) despite one-year paid maternity leave guaranteed for formally employed mothers (UNICEF 2011).

The ambivalence of feminism towards breastfeeding represents the crucial example of (not) breastfeeding taboo (Galtry 2000; Schmied 2001). Sometimes, feminists would even trade gender equality ideals for breastfeeding. For example, in Norway, feminist organisations were against the tripartite model of parental leave, because quotas for fathers would affect breastfeeding (Korsvik 2011). Tomori has identified two opposite positions regarding breastfeeding: one group of scholars (e.g. Hausman) sees breastfeeding as a liberating practice; the other camp (for example, Wolf or Kukla) is criticising breastfeeding promotion as a form of oppression that imposes constraints on women's choice (Tomori 2015: 82).

Currently, the "pro-choice breastfeeding" position is trying to swing back the pendulum. Wolf is one of the leading critics of this new taboo in academic, policy and popular debates on breastfeeding. Many feminist papers criticise the biased information about breastfeeding (Knaak 2006; Casazza 2013; Murphy 1999; Wall 2001; Wolf 2011). Along with the critical re-interpretation of breastfeeding medical evidence, feminists now also question the child-centered model of breastfeeding that neglects the costs of breastfeeding for caregivers, following the words of Rosin: breastfeeding is 'this generation's vacuum cleaner – an instrument of misery that mostly just keeps women down' (Rosin, cited in Tomori 2015: 144).

References

- Beck, Ulrich. 1992. *Risk Society*. London: SAGE.
- Beral, Valerie et al. 2002. Breast cancer and breastfeeding: collaborative reanalysis of individual data from 47 epidemiological studies in 30 countries, including 50 302 women with breast cancer and 96 973 women without the disease. *Lancet* 360(20): 187–95.
- Casazza, Krista et al. 2013. Myths, Presumptions, and Facts about Obesity. *New England Journal Medicine* 368 (5): 446–54.
- Dunn, D. T., M. L. Newell, A. E. Ades & C. S. Peckham. 1992. Risk of human immunodeficiency virus type 1 transmission through breastfeeding. *Lancet* 340(8819): 585–8.
- Forster, Della A. et al. 2010. Women's views and experiences of breastfeeding: positive, negative or just good for the baby? *Midwifery* 26: 116–25.
- Galtry, Judith. 2000. Extending the "bright line": Feminism, breastfeeding and the workplace in the United States. *Gender & Society* 14(2): 295–317.
- Hallberg, Pär & Viktoria Sjöblom. 2005. The Use of Selective Serotonin Reuptake Inhibitors During Pregnancy and Breast-feeding: A Review and Clinical Aspects. *Journal of Clinical Pharmacology* 25(1): 59-73.
- Ioannidis, John. 2014. Discussion: Why "An estimate of the science-wise false discovery rate and application to the top medical literature" is false. *Biostatistics* 15(1): 28–36.
- Jager, Leah & Jeffrey Leek. 2014). An estimate of the science-wise false discovery rate and application to the

- top medical literature. *Biostatistics* 15(1), 1–12.
- Knaak, Stephanie J. 2006. The Problem with Breastfeeding Discourse. *Canadian Journal of Public Health / Revue Canadienne de Sante'e Publique* 97 (5): 412–14.
- Korsvik, Trine Rogg. 2011. Childcare policy since the 1970s in the 'most gender equal country in the world': A field of controversy and grassroots activism. *European Journal of Women's Studies* 18(2) 135–53.
- Marshall, Joyce L., Mary Godfrey & Mary J. Renfrew. 2007. Being a 'good mother': Managing breastfeeding and merging identities. *Social Science & Medicine* 65: 2147–59.
- Murphy, Elizabeth. 1999. 'Breast is best': Infant feeding decisions and maternal deviance. *Sociology of Health & Illness* 21(2): 187–208.
- Quigley, Maria A. et al. 2012. Breastfeeding is Associated with Improved Child Cognitive Development: A Population-Based Cohort Study. *The Journal of Pediatrics* 160(1): 25–32.
- Rippeyoung, Phyllis L. F., Mary Noonanb, 2012. Is Breastfeeding Truly Cost Free? Income Consequences of Breastfeeding for Women. *American Sociological Review* 77 (2): 244–67.
- Schmied, Virginia & Deborah Lupton. 2001. Blurring the boundaries: breastfeeding and maternal subjectivity. *Sociology of Health and Illness* 23(2): 234–50.
- Tomori, Cecilia. 2015. *Nighttime Breastfeeding*. Oxford: Berghan Books.
- UNICEF. 2011. *Multiple Indicator Cluster Survey 2010 (MICS 4)*.
- Wall, Glenda, 2001. Moral Constructions of Motherhood in Breastfeeding. *Discourse, Gender and Society* 15(4): 592–610.
- Wolf, Joan B. 2011. *Is Breast Best? Taking on the Breastfeeding Experts and the New High Stakes of Motherhood*. New Yourk: NYU Press. Kindle Edition.
- WHO. 2002. *Infant and young child nutrition global strategy on infant and young child feeding*. http://apps.who.int/gb/archive/pdf_files/WHA55/ea5515.pdf?ua=1. Accessed on 15 November 2014.
- WHO. 2010. Breast is always best, even for HIV-positive. *Bulletin of the World Health Organization*. 88 (9-10).

IGNJATOVIĆ SUZANA
Institute of Social Sciences (Serbia)

BUTUROVIĆ ŽELJKA
Institute of Social Sciences (Serbia)

HRISTIĆ LJUBOMIR
Institute of Social Sciences (Serbia)