


# Couples talk about breastfeeding: Interviews with parents about decision-making, challenges, and the role of fathers and professional support

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## Abstract

Despite health benefits, sustained breastfeeding rates remain low in the United States, and the role of partners in breastfeeding is not well understood. Using a grounded theory approach, the current qualitative study explored how couples communicate regarding breastfeeding decisions and challenges. Mother-father dyads ( $n = 16$ ) completed individual semi-structured interviews 1 year after the birth of their first child. Following iterative qualitative analysis, three phases of breastfeeding communication emerged: *Should we try this? (Mother's opinion counts)* *How do we make this work? (adjusting and problem-solving)* and *How do we settle into a routine? (gaining confidence, resolving issues)* Findings underscore the complexity of defining the partner role in breastfeeding.

## Keywords

breastfeeding, father, infant, postpartum, women's health

## Why breastfeeding

Exclusive breastfeeding for at least 6 months postpartum is widely recommended internationally by a wide range of major health organizations (e.g. American Academy of Pediatrics, 2012; Horta et al., 2013), due to the extensive and well established health benefits for mother and infant associated with breastfeeding (Horta et al., 2013; Sung et al., 2016; Zhou et al., 2015). An international epidemiological analysis of breastfeeding rates from over 160 low, middle, and high income countries found that both exclusive and any breastfeeding rates are lowest in high income countries, though rates of initiation and exclusive breastfeeding are suboptimal in countries of all income levels (Victora et al., 2016). In the United States, 83.2% of women initiate breastfeeding, yet only 24.9% are able to maintain exclusive breastfeeding through the recommended 6 months postpartum (CDC, 2016).

The majority of women who discontinue breastfeeding before 6 months report that they did not breastfeed as long as they wanted (CDC, 2009). Two large-scale studies

estimate between 60% and 80% of breastfeeding mothers stopped breastfeeding earlier than desired (CDC, 2009; Odom et al., 2013). Within the United States, one of the most comprehensive surveys of breastfeeding discontinuation assessed 1177 adult mothers surveyed monthly from pregnancy through 1 year postpartum. Among the 60% of women who stopped breastfeeding earlier than desired, the most commonly cited reasons for involuntary weaning were difficulty with lactation (most commonly, latching) and perceived insufficient milk supply or infant weight (Odom et al., 2013). Additional reasons for involuntary weaning included maternal or infant illness or the need to take medicine, and becoming fatigued with the effort of pumping milk. Additional studies of mothers' reasons for

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breastfeeding discontinuation have underscored similar concerns. For example, in a sample of 500 mothers in Nova Scotia, discontinuation was reported to be most commonly prompted by concerns about milk supply and the inconvenience or fatigue associated with breastfeeding (Brown et al., 2014). In addition to the physical aspects of breastfeeding, additional psychological concerns such as social pressures, inconvenience, embarrassment, body image issues, and lack of support have been identified as factors associated with early termination of breastfeeding (Brown et al., 2016). The high number of breastfeeding challenges and involuntary weaning rates underscore the importance of research to optimize effective delivery of support, information, and resources to facilitate breastfeeding.

A variety of methods have been used to explore the physical and psychological factors that are associated with longer breastfeeding duration. Previous qualitative research in Australian and American samples of women who successfully maintained breastfeeding through their target duration has identified a trend in which common breastfeeding challenges (latch, supply, exhaustion, stress) build up to produce a low point or turning point where women must employ a range of psychological strategies to continue breastfeeding. These strategies include self-care, challenging negative thoughts, seeking technical support and social support, and setting small goals (O'Brian et al., 2009; Schafer et al., 2018). Among cross-sectional and prospective quantitative designs, commonly identified psychosocial predictors of breastfeeding success include early breastfeeding intentions and breastfeeding self-efficacy (de Jager et al., 2014; Henshaw et al., 2015; Lau et al., 2018; Scott et al., 2006). Together, these findings suggest that a combination of technical breastfeeding knowledge and psychological coping skills are key for continuing breastfeeding despite common challenges.

Several of the psychological factors strongly associated with breastfeeding, such as self-care, self-efficacy, and strong breastfeeding intentions, are found to be fostered through relationships with key individuals in the breastfeeding woman's perinatal experience. For example, breastfeeding self-efficacy theory suggests that a woman's confidence in her ability to breastfeed is developed based on verbal appraisal from trusted individuals, observational learning from other women's breastfeeding experiences, along with regulation of stress (Dennis, 1999). A woman's intention to breastfeed prenatally is also an established predictor of breastfeeding duration (Bai et al., 2009), and is closely correlated with the attitudes of a woman's partner (Mitchell-Box et al., 2013). Thus, a woman's close social network plays an important role in the breastfeeding experience. Specifically, support from lactation consultants has been associated with higher exclusive breastfeeding rates (Francis and Dickton, 2019), along with infant's maternal

grandmother's influence (Barr et al., 2018; Negin et al., 2016), and infant's father influence (Wolfberg et al., 2004).

Therefore, among breastfeeding women who live with a partner, it is important to explore the specific role of the partner in breastfeeding initiation and continuation. Previous qualitative work conducted with fathers in Quebec, Canada investigating co-parent father<sup>1</sup> roles in breastfeeding identified three major domains of father involvement in breastfeeding: contributing to decision making, providing emotional support for the mother, and being responsible for family functioning in areas other than breastfeeding (deMontigny et al., 2018). Multiple qualitative studies from fathers' perspectives suggest some challenges in determining what role the father should play in breastfeeding support. For example, fathers have described their role as a secondary, or "supporting role" to the mother (Rempel and Rempel, 2010), which involves "negotiating a space" for themselves in the breastfeeding decision making process (deMontigny et al., 2018). Fathers interviewed using open-ended survey questions indicated that fathers were generally supportive and interested in being involved in breastfeeding, but reported feeling helpless, excluded, and uncertain about how to support their partners (Brown and Davies, 2014).

Recent cross-sectional and prospective surveys with couples suggest that partner support of breastfeeding has a rather complicated relationship to maternal breastfeeding duration outcomes. On one hand, first time mothers who identified having breastfeeding support from their partner during the third trimester or in the early postpartum period have been found more likely to initiate breastfeeding and have longer breastfeeding duration (Hunter and Cattelona, 2014; Kessler et al., 1995), while mothers who initiated formula feeding indicate perceived father support of formula over breastfeeding (Arora et al., 2000). In contrast, recent prospective research active verbal appreciation of breastfeeding uniquely predicted *lower* likelihood of breastfeeding duration (Rempel et al., 2017). This was especially true for couples in which the father desired a longer breastfeeding duration than the mother. In that study, fathers' *responsiveness*, (helping the mother feel comfortable breastfeeding publicly, noticing how the mother wants him to support breastfeeding), was the only type of father breastfeeding support that predicted longer breastfeeding duration outcomes.

Together, research on father role in breastfeeding suggests a complicated and inconsistent relationship between father breastfeeding support and maternal experience of breastfeeding. Therefore, more research is needed to explore the communication and decision-making dynamics of couples as they decide to initiate and maintain breastfeeding. It is critical that study methodologies on this topic include mother and father perspectives explored as a dyad, rather than solely a maternal or paternal perspective, to determine how breastfeeding support is expected, offered, and received.

While previous studies have investigated the perspectives of mothers and fathers separately, very few studies have investigated the mother-partner dyad perspective on breastfeeding experiences and support. Of those who do include both mother and partner, interviews have not focused on the interaction between mother and partner, but rather on the couple's shared perspectives about external influences at the community and organizational level (Majee et al., 2017). As identified by previous family researchers, interviewing family members together is a good strategy for learning about areas of consensus, but separate interviews are necessary to compare and contrast perspectives of individual accounts (Reczek, 2014).

## Current study

The current study explores first-time mother-father dyads' perspectives on and interactions surrounding infant feeding during the first year postpartum. Mother-father pairs are interviewed separately to investigate agreement, discrepancies, and tensions between perspectives on breastfeeding and support. Specifically, we explore the perceived challenges, resources, and roles that mothers and fathers experienced related to breastfeeding, along with the communication and decision making processes that couples engage in around breastfeeding in the first year of parenthood.

## Method

### Participants

All participants were first-time mothers who had participated in previous university IRB-approved women's health research and consented to be contacted for future studies (IRB #OH1-11-00335). A study invitation was sent to all women who met the following inclusion criteria: first-time mother living with or married to a partner, English speaking, age 18 or older, with an infant between 10 and 16 months postpartum. Women were invited by email to participate and to invite their partners to participate. Interviews were conducted and discussed weekly until the research team agreed that data saturation had been met. Of the 25 women invited, 18 women and their partners (36 participants) completed interviews. Two couples' interviews were not able to be transcribed accurately due to noise or recorder error, resulting in 16 couples (32 participants) included in the current analysis.

Participant characteristics are summarized in Table 1. All participants were married or living together, and all couples were white, heterosexual biological mother and biological father pairs. Three couples had twins while all others were single infant families. Mothers' ages ranged from 23 to 36 years old ( $M = 29.4$ ), and family income ranged from 20 to 39,000 annually to over 120,000

**Table 1.** Participant characteristics.

	<i>n</i> (%)
Exclusive breastfeeding duration <sup>a</sup>	
None	2 (12.5)
<2 weeks	3 (18.7)
2 weeks–3 months	1 (6.3)
3–6 months	1 (6.3)
6–12 months	3 (18.7)
More than 12 months	6 (37.5)
Maternal work status at 12 months <sup>c</sup>	
Full time outside of home	8 (50)
Part time outside of home	3 (18.7)
Stay-at-home parent	5 (31.3)
Maternity leave <sup>c</sup>	
8–10 weeks	4 (25)
11–13 weeks	7 (43.8)
Not applicable	5 (31.3)
Number of infants <sup>a</sup>	
Single birth	13 (81.3)
Twins	3 (18.7)
Household income <sup>a</sup>	
20,000–39,999	2 (12.5)
40,000–59,999	3 (18.7)
60,000–79,999	5 (31.3)
80,000–99,999	1 (6.3)
100,000–119,999	1 (6.3)
120,000 and above	3 (18.7)
Prefer not to answer	1 (6.3)
(Maternal) education <sup>c</sup>	
Some college	2 (12.5)
College graduate	8 (50)
Graduate degree	5 (31.3)
Prefer not to answer	1 (6.3)
(Maternal) age <sup>c</sup>	
25–29	6 (37.5)
30–34	8 (50)
35–39	1 (6.3)
40–44	1 (6.3)
Relationship status <sup>a</sup>	
Married	15 (93.7)
Living together	1 (6.3)
Race <sup>b</sup>	
White	32 (100)

The total sample consisted of 32 participants (16 heterosexual male and female couples).

<sup>a</sup>These variables were reported for each couple as a unit ( $n = 16$ ).

<sup>b</sup>These variables were reported for each participant individually ( $n = 32$ ).

<sup>c</sup>These variables were reported for the female participants only ( $n = 16$ ).

annually (median = 60–79,000). Slightly over half of the sample reported breastfeeding exclusively for 6 months or longer (56.25%). The homogeneity of the sample is representative of the homogeneity among breastfeeding partnered women in the original database who agreed to be contacted for future research participation.

## Procedure

University IRB approval was obtained (IRB# SU 13-2 ROLE) and all participants completed written informed consent before participating in one-time individual interviews. Interviews were conducted between June and August 2013 by two female undergraduate research assistants and the primary investigator (a female clinical psychologist). All interviewers completed training and practice conducting qualitative interviews. Interviewers did not have prior relationships with any of the research participants, and all participants were informed that the goal of the research interviews was to learn about participants' experiences with the transition to parenthood. Semi-structured interviews were conducted based on an interview guide developed by the primary investigator. The interview guide was used to introduce key topics related to the study interest areas, such as transitioning to parenthood, infant feeding decisions, stress and mood changes, and communication with the co-parent partner. Prompts were broad and general open-ended questions, allowing significant flexibility in participant response and elaboration. Interviews were audio recorded using digital recorders (ranging in length from 30 to 70 minutes,  $M = 46.09$ ) and transcribed verbatim. All mother and father interviews were conducted in separate rooms at the participants' homes with infants present for the majority of interviews. Participants received a \$25 retail gift card for participation. Analysis of the interviews for themes related to couples' communication about stress and mood changes was published previously (Henshaw, Durkin & Snell, 2016).

## Qualitative approach and research paradigm

A grounded theory framework following the methods and philosophical assumptions described by Corbin and Strauss (2008) was used to guide decisions for sampling, coding, and reporting in this study. The purpose of the current study was to develop an understanding of the processes involved in couples' decisions to initiate and continue breastfeeding, with goals of generating new theoretical directions. Thus, a grounded theory approach as defined by Corbin and Strauss (2008) is an appropriate theoretical match.

Theoretical sampling (Corbin and Strauss, 2008; Taylor and Francis, 2013) was used to initiate the qualitative investigation. The target population of living-together couples who initiated breastfeeding was used to guide sampling; the desire to learn about the beginning, middle, and end stages of infant feeding decisions from each parent's perspective guided the semi-structured interview guide questions and plan to interview parents separately. Finally, the goal of developing a theoretical framework of decision-making in infant feeding shaped the analysis plan of systematically and iteratively identifying codes through team discussion and refinement until thematic saturation was achieved.

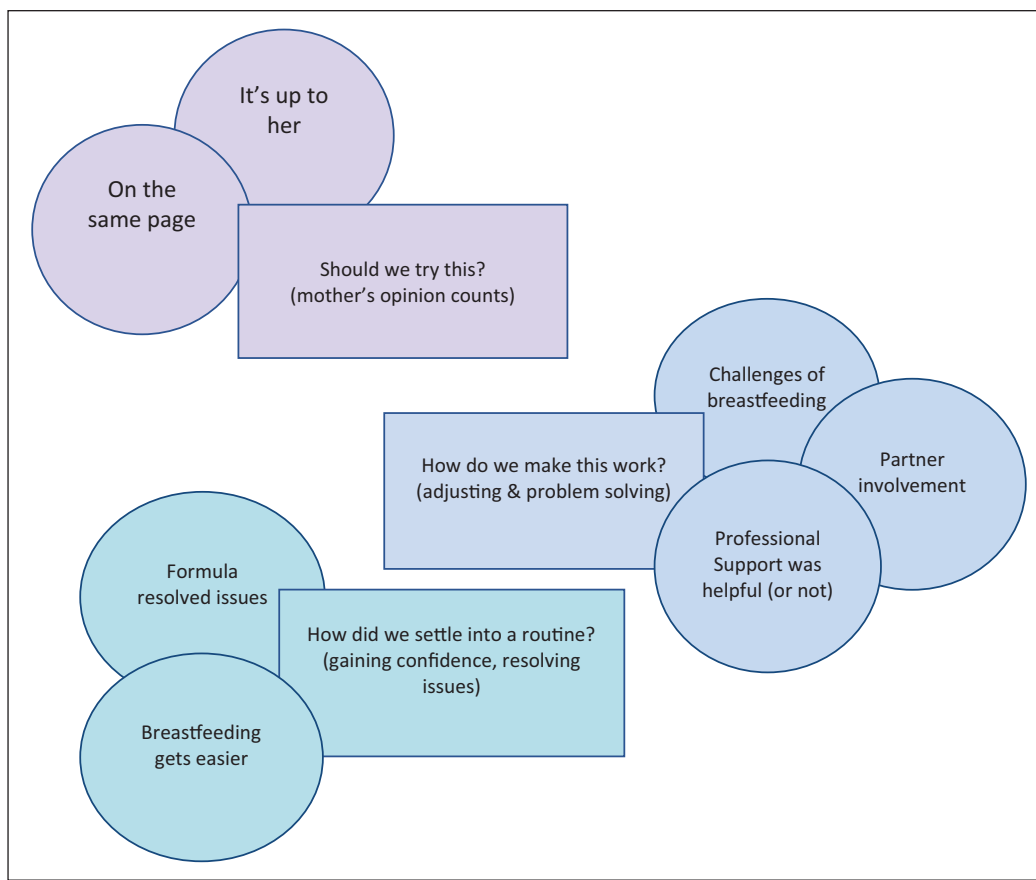
## Coding process

Beginning in June 2019, three undergraduate psychology students and one clinical psychologist analyzed the 32 identified interview transcripts from 16 couples. All members of the research team were familiar with current literature regarding breastfeeding duration predictors and the role of fathers in breastfeeding outcomes; however, no themes were identified in advance but were rather derived from the data. Analysis was informed by a grounded theory framework using an iterative open coding-into-axial coding process as described by Corbin and Strauss (2008) and Taylor & Francis (2013). Emergent themes were discussed, revised, and coded using an iterative process. Breastfeeding decision making, challenges, and partner roles were the primary topic of interest in the grounded theory exploration. Saturation was considered achieved when reading of interview transcripts produced no new themes or codes, but rather were captured in already developed themes. NVIVO (version 12) software was used in the final stages of coding, and final refinement of thematic descriptions and relationships was completed by the primary investigator. Within results, it is important to indicate when both members of a couple are speaking about a similar topic in agreement or disagreement; therefore, participants are distinguished from each other by a participant number and their role as mother or father (e.g. couple 8 father). This number does not match the original data collection participant number and cannot be linked to identifying information regarding original participants. Original identified transcripts and all notes from thematic coding stages are stored securely in electronic form.

## Results

### Overview of themes

The results of the current study, summarized in Figure 1, were categorized into three major themes regarding breastfeeding, reflecting dilemmas, and their resolutions that couples described addressing at each phase of the infant feeding process: *Should we try this? (mother's opinion counts)* *How do we make this work? (adjusting and problem-solving)* and *How did we settle into a routine? (gaining confidence, resolving issues)*. The first overarching theme, *Should we try this? (mother's opinion counts)*, captured couples' decision making process around breastfeeding initiation, typically occurring during the prenatal period prior to experiencing breastfeeding. *Should we try this?* includes two subthemes: *On the same page*, and *It's up to her*, capturing the couples' agreement and roles in the decision. The second overarching theme, *How do we make this work?* encompassed the common feeding struggles and coping strategies that couples experienced, typically at greatest intensity during the first weeks or months of breastfeeding. This theme involved three primary subthemes outlining the primary challenges and the role of professional and partner



**Figure 1.** Central themes of mother and father interviews about breastfeeding.

support in addressing those challenges. These subthemes are titled: *Challenges of breastfeeding*, *Professional support was helpful (or not)*, and *Partner involvement*. In these subthemes, the couples' initial intention for breastfeeding was reconciled with challenges or difficulties faced, and alignment of women's expectations for help from professionals and partners with the actual help received was noted as important. The final overarching theme, *We settled into our routine*, captures the couple's resolution of feeding challenges, either through improved ability to manage breastfeeding or through introduction of formula. These subthemes are titled *Breastfeeding gets easier*, and *Formula resolved issues*. Resolution represented stability for couples, either in an established breastfeeding routine or an established formula routine.

#### ***Should we try this? (mother's opinion counts)***

The first stage described in couples' infant feeding experience was the decision to try breastfeeding or not. Unanimously, couples reported that this decision was made during pregnancy before delivery, though couples described varying levels of emotion and commitment attached to the decision. Couples tended to describe one of two ways of coming to a

decision about infant feeding: either the couple felt so much agreement in their opinion that they were enthusiastically "on the same page" about breastfeeding with little discussion or deliberation, or if levels of enthusiasm or position on infant feeding differed, fathers deferred quickly to the mother's position, recognizing that the physical burden of breastfeeding, and therefore the final decision about feeding, should be hers. Fathers in this theme frequently summarized this as, "it's up to her." Notably, an explicit two-way discussion and debate about whether or not to breastfeed was not described by any of the couples.

***On the same page.*** Many couples shared the same perspective not only on whether to breastfeed or not, but also on their primary motivations to do so. In this study, couples were interviewed simultaneously and separately, which allowed each parent to tell individually what factors were most important in infant feeding decisions. While many motivations to breastfeed (or not) were mentioned across couples, such as health, financial savings, and emotional bonding, most couples who were "on the same page" about breastfeeding also were on the same page about why they thought it was important. The most notable aspect of this theme was the degree of agreement, even similar language

and phrasing, reported by couples. For example, both partners in this couple referred to “natural” values as their shared motivation for breastfeeding:

*I feel, you know we're pretty natural people anyway, as far as the way we live our life (couple 08 father),*

*I just feel like it's the natural way (couple 08 mother).*

Agreement between couples was found in a range of breastfeeding motivations, including financial and health benefits. Some couples felt their shared values were already so known to each other that they did not recall explicitly discussing the decision to breastfeed, instead stating commonly that they “just knew” what they would do, and why:

*We never talked about it, we knew that breastfeeding was cheaper*

(couple 01 father)

*We knew we would [breastfeed] for financial reasons*

(couple 01 mother)

**It's up to her.** Couples who did not describe being naturally “on the same page” about feeding intentions shared that decisions were made primarily by the mother, with the father either offering an opinion but declaring the decision to be hers, or (more commonly), holding back or silencing his opinion in order to defer to the mother's opinion. Fathers varied in both strength of opinion and involvement in the breastfeeding decision. Among couples that had an active breastfeeding conversation, it was found that regardless of whether fathers' opinions paralleled or differed from the mother's, they quickly deferred to their partner's decision: [*I was for breastfeeding as well but if she had been pro formula, I wouldn't have pushed very hard (couple 03 father)*]. Some fathers described their opinion about breastfeeding as neutral, being supportive of whatever decision the mother made: [*I sort of took a back seat with that [breastfeeding decisions] cause to me whether or not she was going to breastfeed was kind of a decision that was up to her, you know, and I told her before that I would kind of support whatever, you know, if she wanted to do it or if she didn't and kind of do as much as I can either way (couple 16 father)*]. Fathers with differing opinions on breastfeeding reported holding back their opinions to avoid imposing their views on their partner. In several instances like this, mothers interpreted the fathers' position as neutral or apathetic. The following couples' example illustrates this theme: [*I wasn't sick when I had formula as a child, but I just let her make that decision (couple 9 father)*]; [*Um, I don't really think [partner] cared (couple 09 mother)*].

In sum, all fathers reported recognizing the mother's opinion as the ultimate decision about feeding, whether they were initially on the same page or not. Some fathers, especially the few who differed from their partner's views

on feeding, cited this as a reason to hold back from discussing feeding decisions openly.

### **How do we make this work? (adjusting and problem-solving)**

Couples noted many challenges that impacted their breastfeeding experience. Partners noted that both professional support and partner involvement were significant support systems that either eased or hindered their breastfeeding experience. The presence or lack of effective support in these domains was a major thread throughout couples' discussion of breastfeeding challenges.

**Challenges of breastfeeding.** There were a wide variety of stressors that affected the breastfeeding experience. Among the couples interviewed, common challenges involved infants struggling to latch [*it was so frustrating because we found out she wasn't sucking (couple 07 mother)*], the lack of milk production [*I wasn't producing enough milk. I was eating all the calories and it wasn't panning out (couple 10 mother)*], and self-criticism [*I was judging myself. . . I really bent over backwards (couple 03 mother)*]. The common challenges often led to feelings of pain, anxiety, and failure. Issues with breastfeeding and latching tended to precipitate feelings of pain and anxiety [*his issues with breastfeeding caused a lot of damage and there was a lot of pain (couple 03 mother)*], [*What made me a little anxious was a lot of people had opinions about feeding (couple 07 mother)*]. Mothers who could not meet their own expectations often felt as though they failed [*I felt like a failure and I wasn't as forgiving to myself as I should have been (couple 03 mother)*]. The majority of couples reported the first few weeks postpartum as being the most challenging; the agreement between partners regarding this time-frame is notable: [*It was really difficult. That lasted the first six to eight weeks, it was very, very difficult (couple 04 mother)*], [*At the beginning, she doesn't know what she's doing. [In the beginning], there was stress (couple 04 father)*]. Two forms of support emerged as especially critical in the breastfeeding experience that either aided, or hindered, the couples' ability to overcome the frustrations: professional and partner support.

**Professional support was helpful (or not).** All couples interviewed delivered their infant at the same hospital system, allowing all to have similar access to in-hospital lactation support, breastfeeding class, and breastfeeding groups postpartum. However, differences in insurance coverage or other logistical resources led couples to vary in degree of additional professional support available. Despite similarities in the delivery setting, new mothers' experiences of the professional breastfeeding support they received varied greatly, with some experiencing the professionals as extremely beneficial and others not beneficial at all. The mothers who noted a positive experience often did not

experience any initial issues with breastfeeding [*The consultant that I had was very good and supportive. I didn't have any problems getting her to latch on.* (couple 01 mother)] and/or felt that they received sufficient attention [*I felt that they were there for me* (couple 08 mother)] and support [*they just provided support and a lot of resources* (couple 07 mother)]. The mothers who had an unpleasant experience reported primarily concerns about feeling valued and respected, rather than concerns about the technical expertise of the professional staff. For example, some women reported feeling the professionals were rushed [*Some nurses were like 'I don't really have time to do this with you right now' and had to move along to someone else* (couple 10 mother)], were too aggressive [*the nurse kept trying to adjust me and she was just really pushy with it* (couple 09 mother)], or were judgmental of the mothers' feeding decisions [*I feel like they weren't giving me an option* (couple 11 mother)].

It is notable that there were few discrepancies among the partners regarding their views on professional support. This particularly occurred when mothers had a negative experience with the nursing staff and their partners either did not comment on the issue, had a differing experience, or demonstrated a lack of confidence regarding the effectiveness of the hospital staff. For example, in one couple the mother reported that she did not receive adequate attention from her nurse [*Some nurses [did not have time] and had to move along to someone else* (couple 10 mother)], however, her partner's opinion differed and he thought the nurse was helpful [*The breastfeeding consultant showed her a few things and that helped out a lot* (couple 10 father)]. In another couple, the mother reported that the lactation consultants were not beneficial, [*I didn't think the lactation counselors in the hospital were helpful at all* (couple 04 mother)], while her partner's response demonstrated an element of unsureness, [*I think meeting with the LC in the hospital probably helped a little bit* (couple 04 father)]. As many mothers' critiques of the breastfeeding support were about emotional responsiveness and perceived availability of the consultant, it is possible that those interpersonal dynamics were not always experienced or observed by the partner.

**Partner involvement.** The extent to which fathers were involved or helpful in the breastfeeding experience was critical in how mothers either overcame, or did not overcome, their challenges. Fathers often reported that they initiated support and help, [*The first thing I did was just ask her, like what can I do* (couple 03 father)], or addressed their limited role in the breastfeeding process, [*I mean for [mother] getting up every two hours. . . that was hard, but there was nothing I could do* (couple 15 father)] [*It seemed silly for me to [attend to the baby] and then. . . lose the sleep* (couple 14 father)]. Mothers often reported that they either asked their partner for help, [*I'd really like him to ask*

*how he could help me more* (couple 14 mother)], or that their partner independently offered to help, [*He jumps right in. He's most helpful,* (couple 15 mother)].

When mothers were pleased with their partner's support, they noted it most helpful when their partners helped them with feeding responsibilities [*We would both help during the overnight feeding. . . it worked* (couple 04 mother)], gave them positive affirmations [*He would always tell me that [I'm] smart and strong* (couple 10 mother), and encouraged mothers to take time for themselves [*[father] would encourage me to take a break and get out of the house* (couple 04 mother)].

Mothers and fathers both discussed "adjusting" their coping and communication for more effective working together. For example, this father describes adjusting his support from offering solutions to offering to listen and support:

*I think earlier I would make the mistake of trying to offer a solution cause I thought this might be the right answer and I don't think she wanted to hear a solution as much as she wanted somebody to listen and just maybe offer a solution but not in the same way. More of just being somebody to listen, and then maybe contributing what you feel at the end, but saying like, but not being a person who automatically assumes they know how to fix the problem or that there is something that I could do to fix the problem, more just be there for her and listen. . . (couple 5 father)*

When mothers were not pleased with their partner's support, it was often a result of the mothers' pressure on the self, [*He always offered. But I felt like it was my responsibility, my duty to take care of the baby, so I resented him* (couple 09 mother)], or a lack of clear communication [*I was irritated that he didn't get up early, but I didn't ask him to* (couple 14 mother)]. Some mothers who report that their partner is very helpful also reported adjusting their communication to be more direct in order to receive more help from the partner: *We just keep a dialogue going. I do write lists and ask him to do stuff, because if I don't ask him to do it he doesn't do it. He'll say, "You've got to ask me if you want me to do anything" type of thing, so I've learned to be a little bit more vocal about what I want. . . he's really good at sometimes, if I feel overwhelmed, he'll say, "Let me do the dishes, let me do that."* (couple 15, mother).

### **How did we settle into routine? (gaining confidence, resolving issues)**

Many of the partners' initial stressors dissipated or improved throughout time as a result of breastfeeding itself improving or the introduction of formula feeding.

**Breastfeeding gets easier.** The majority of mothers reported that after the first couple of weeks and months, their breastfeeding experience improved. As a result of the improved

experience, some mothers found they had more flexibility and greater autonomy [*after the first three months, once he got the hang of breastfeeding, I started being able to leave the house* (couple 03 mother)], while others began to enjoy the practice of breastfeeding [*And now I really enjoy it, I'm sad about cutting it out* (couple 13 mother)]. Overall, mothers reported that issues with breastfeeding—whether latching, pain, chafing, or exhaustion—mostly began to lessen after the initial stress of breastfeeding:

*It was a lot harder than I thought it was gonna be. It definitely stressed me out and it made me emotional in the beginning, but like once we got it down, it went really well. And now I really enjoy it, I'm sad about cutting it out, but at the time—in the beginning it's really hard. I mean you don't know when they're hungry or when they're not and when they just cry and you're like maybe they're hungry, so. (couple 08, mother)*

*It was just no sleep and pretty much breast feeding 24 hours a day. It was just really difficult. And that lasted probably the first six to eight weeks, it was very, very difficult. Then it started to get better from there gradually (couple 12, mother)*

Unlike other topic areas, this theme was mentioned nearly exclusively by mothers, with very few fathers mentioning the gradual improvement of the breastfeeding experience. Only in the case of a few couples did the “it got easier” theme appear in both parents’ interviews [*After the initial month, it just got better* (couple 03 father)].

*The very very beginning was really hard for her, just because it started and she had a lot of problems with it hurting her at first. But it didn't take too long for her kind of find a good technique and method, and that really helped things, and after, things were really smooth as far as nursing. (couple 16, father)*

**Formula resolved issues.** Among mothers who had initiated exclusive breastfeeding, eventual initiation of formula often was described as a solution to a building problem or concern, such as infant weight trajectory or latch difficulty. For the majority of couples, the introduction of formula was initially emotionally taxing but ended up improving the couple’s overall breastfeeding experience. Many women were distressed by the transition to formula because of a sense of failure or guilt: [*She started to lose weight and at first I felt like I had done something wrong* (couple 10 mother)], [*I had these high expectations that you're never gonna have formula, you're gonna be breastfed the whole time* (couple 12 mother)]. Eventually, the same mothers noted that formula significantly improved their experience: [*And then, I got over it and it was better* [laughs] (couple 12 mother)]. A trend of “coming to terms” with formula emotionally also often involved resolving the concerns that led to formula introduction [*Once we actually started [formula*

*feeding], the tension kind of released itself a little bit* (couple 16 mother)].

The theme of formula resolving issues emerged similarly even across very different time periods of exclusive breastfeeding. For example, one mother describes the transition after 3 days of breastfeeding:

*After three nights and three days of trying, I got her home and she just wasn't full. I was like, “All right, let's try the formula.” This one morning she was crying all night so we gave her a bottle of formula and she was a different baby. We were like, “Okay.” Really, I mean, my point of view . . . we had so many family members that were stopping by and I just . . . I was glad that they were all able to feed her and I didn't have to hide away for two hours to nurse. She was still getting what she needed so, yes. (couple 10, mother)*

In contrast, another mother describes the transition to formula after 5 months of breastfeeding: *I nursed him until he was like just shy of 5 months old and you know you go into certain things planning like I want to do this for x amount of time sort of thing and then sometimes you feel like you felt short if for some reason you can't do that. And I had to quit nursing him because I got a clogged duct on my nipple. . . . He would get it open, I feel like it would go away and then it would just come back. And so like, the only way to make this go away is if I just dry up. And so, you know I was really sad, too, because I was like no I was supposed to do this for at least two more months (couple 13, mother).*

For this second mother, she credited her partner with helping her come to terms with the transition to formula: *He kept reassuring me like you did it a good amount of time, you, you know gave him what he needed and everything, like that was a long time and everything. So he was, in that moment, too, he really helped to reassure me that I did everything that I could (couple 13, mother).* This theme of fathers helping console and reframe mothers’ disappointment with the transition to formula was common.

Similar to mothers, fathers generally noted how formula improved the breastfeeding experience. It is notable that many fathers commented on how the transition was emotionally challenging for their partner [*I know she struggles a lot with the emotional aspects of the detachment of not breastfeeding, or not being the one who provides everything for him* (couple 06 father)]. Unlike mothers, fathers did not report distress or guilt over the transition [*I did not have a problem with it at all. It wasn't even an issue in my mind* (couple 07 father)].

Fathers often noted they were pleased with the transition to formula due to the resolving of concerns [*immediately we switched her onto formula; we knew she was getting her nutrients and minerals* (couple 11 father)], or because they were



able to participate more in the feeding process [*That transition has let me do more when I'm available* (couple 06 father)].

## Discussion

### Study purpose/results

The purpose of this qualitative study was to better understand the role partners play in breastfeeding for new mothers. Our analysis of the interviews resulted in the appearance of several themes representing three points of potential uncertainty or tension, followed by resolution. One of the major themes of our study was *Should we try this? (mother's opinion counts)* which captured couples' prenatal decision making process around initiating breastfeeding or not. The majority of couples suggested either being on the same page or deferring to the mother's decision. The second overarching theme, *How do we make this work? (adjusting and problem-solving)*, encompassed the common feeding struggles that couples experienced as well as how they coped with them. These feeding struggles were described as requiring a seeking out of support, from professionals and/or partners. Professional support and partner involvement were two crucial factors that either helped or hindered the breastfeeding experience. Notably, mothers and fathers described having to adjust to each other's expectations regarding the type and frequency of involvement the father would have in breastfeeding support. The final overarching theme, *How did we settle into a routine? (gaining confidence, resolving issues)*, captured the couple's resolution of feeding challenges, either through improved ability to manage breastfeeding or through the introduction of formula.

Previous research establishes that intentions to breastfeed are an important predictor of breastfeeding, and are typically developed prenatally (Meedya et al., 2010). The results of this study suggest that prenatally, the decision to intend to breastfeed did not involve extensive debate or discussion for the majority of couples. Rather, regardless of the reason for choosing breastfeeding or not, many couples reported being so in step with each other's position that they naturally knew whether they would choose breastfeeding or not, based on shared values and perceptions of breastfeeding as fitting their natural, economically savvy, or evidence-based lifestyle. Among those who did not report being so well aligned, all fathers recognized the mother's opinion as holding greater weight than their own, resulting in reluctance to share a dissenting opinion. A qualitative interview study with fathers in rural Quebec (deMontigny et al., 2018) found similarly that a portion of fathers also deferred to the mother's choice; however, in contrast with our findings, deMontigny had many examples of fathers who actively advocated for (or against) breastfeeding and engaged with the mother in a discussion

or disagreement about the decision. As both qualitative samples were relatively homogeneous, this question regarding fathers' beliefs about breastfeeding decision making will be important to explore quantitatively with a diverse sample of couples in order to broadly evaluate the range of beliefs, cultural backgrounds, and relationship dynamics that might contribute to variations in the way opinions about breastfeeding are negotiated between two-parent couples. Correlation between maternal and paternal attitudes about breastfeeding has been found in quantitative studies (e.g. Mitchell-Box et al., 2013), and partner attitudes and support for breastfeeding are predictors of breastfeeding behaviors generally (Hunter and Cattelona, 2014; Kessler et al., 1995, Arora et al., 2000). However, fathers' active verbal appreciation of breastfeeding prospectively is found to predict *lower* likelihood of breastfeeding duration (Rempel et al., 2017). What it means for a male partner to express support for breastfeeding and to share pro-breastfeeding attitudes in a sensitive manner that respects the autonomy of the woman's decision making regarding her body is a topic that should be explored further in future work, as this seems to be an important and complex part of communication about breastfeeding between partners.

Challenges establishing and maintaining breastfeeding were identified by nearly all participants, yet the perceived helpfulness of professional and partner support varied greatly. The challenges reported by parents in this study were consistent with those reported by other studies of breastfeeding barriers, such as latching, milk supply, wounded nipples, and sleep deprivation (Feenstra et al., 2018). Previous studies have suggested that breastfeeding challenges build up to critical points which must be resolved through personal coping or seeking support from others (O'Brian et al., 2009; Schafer et al., 2018). In the current study, successful professional support experiences resulted in mothers feeling more confident or resolving a breastfeeding barrier. Importantly, when women described disappointment with professional support, the area of deficiency they reported was in how the support staff made them feel: rushed, judged, or invaded. The role of emotional support and validation in effective lactation support appears to be quite important for mothers when evaluating the quality of the support received.

The findings of this study echo the complexity of the mother-partner breastfeeding roles that others have reported (e.g. Rempel and Rempel, 2010). Previous research has identified fathers as struggling to "find a place" in breastfeeding (Brown and Davies, 2014; deMontigny et al., 2018). In the current study, the ambiguity regarding the role of fathers arose when both mothers and fathers discussed sharing responsibilities. Anticipating the needs of the mother and stepping in to offer emotional or instrumental support was a key feature of mothers' positive experiences with partner support. On the other hand, mothers who felt

less satisfied with partner support indicated a lack of the partner anticipating or jumping in with support; rather, the partner waited to be asked or instructed how to help. The perspective of fathers in this study suggested that some fathers saw their help as less important, or perhaps felt there was not anything they could do to help with breastfeeding. Whether through facilitating communication between partners or through partner-focused education, introducing partners to specific supportive actions could reduce this ambiguity. For example, one commonly reported place or role that fathers in the current study identified was helping the mother “take a break” from the childcare responsibilities between infant feedings. While partners may not see this as directly supporting breastfeeding, mothers reported this being a very helpful part of managing the physical and emotional strain of breastfeeding. Recent research suggests this “time for self” during the postpartum period may be protective against depression risk (Dennis, 2016). Facilitating agreement among couples about how breastfeeding can be supported by the partner is an area to be explored further in future research.

### *Limitations and future directions*

The current study findings should be considered in the context of the following limitations. Despite efforts to recruit a more diverse sample, the final participants were primarily white heterosexual parents with relatively high incomes and education levels. The expectations and dynamics of the couples interviewed for this study should not be generalized to other samples; instead, these findings are valuable for building theory and hypotheses about communication among partners, which should be investigated in future qualitative and quantitative designs with diverse samples. Further, the interviews were conducted in 2013, and changes in couple communication and breastfeeding attitudes since that time should be assessed with future research as well. In particular, emerging trends in remote work environments stemming from the COVID-19 pandemic will be important to evaluate in relation to the themes of parental division of labor and return to work as they are described in these interviews.

An important next step in this research is to purposefully investigate couples’ breastfeeding communication and expectations in couples across diverse backgrounds, especially to investigate breastfeeding experiences among women in underrepresented groups. For example, more research is needed about how breastfeeding expectations are communicated and supported in LGBTQIA couples. Seeking out diverse perspectives on co-parenting will contribute to a richer understanding of the expectations breastfeeding mothers have for the roles and support behaviors of a co-parent partner. Given the sensitivity of discussing parental roles, expectations, and satisfaction with the coparent relationship, studies should employ multiple methods of data collection, such as focus group, couple interviews,

and the method used in this study of separate interviews of couple parents.

Understanding trends in the communication and support needs of new parents can lead to the development of more inclusive breastfeeding support and education programs that address opportunities and challenges for co-parent support and involvement. While the majority of breastfeeding education and support is focused on the mother, it is valuable to recognize that partnered mothers will have the potential support, but also potential challenge, of communicating breastfeeding roles and expectations with a co-parent partner. Designing and evaluating feasible interventions that acknowledge and address the co-parent role are an important next step in this research field.

### *Implications for practice*

The current study demonstrates a wide range of expectations and communication within first-time parent couples. Many fathers reported feeling unsure of the role they should play in breastfeeding decisions and support, sometimes leading some mothers to perceive fathers as less engaged or helpful than would be ideal. For practitioners supporting breastfeeding, it is possible that exploring couples’ explicit expectations about breastfeeding (and roles within the feeding process) prenatally could increase the satisfaction of both parents with the level of involvement and support of mother and father. Furthermore, providing pathways for supportive partner behaviors, that both match the explicit expectations, and also give the father a sense of contribution to the decisions, is crucial for having a smooth first-time breastfeeding experience.

Further, the strong and mixed reactions of mothers and fathers to the professional support received suggests that the emotional experience of learning to breastfeed is an important part of lactation instruction to address. Women who found support unhelpful cited experiences of feeling frustrated, invaded, or judged as the reasons for their dissatisfaction—these concerns are more about the ability of a consultant to deliver information sensitively than about the ability to correctly demonstrate a technique. While there are also many examples of women having very positive experiences with professional support, the mixed findings present an opportunity to consider the importance of addressing emotion as part of lactation consultation.

### **Conclusion**

In this sample, three major windows of uncertainty and decision making appeared in couples’ recollections about breastfeeding their first child. First, while many couples reported being on the same page with breastfeeding decision making, some fathers quieted their opinions about infant feeding in acknowledgment that the final decision would be the mother’s. Second, all couples identified some breastfeeding

challenges, particularly in the early weeks postpartum, and cited professional and partner support as being key factors in managing (or not) these challenges. Finally, couples' challenges with breastfeeding were resolved in one of two ways: either things became easier and more routinized with breastfeeding, or the decision to transition to formula was made. Lack of clarity about the appropriate role for fathers appeared within all of these themes, suggesting that future research should evaluate how couples negotiate the father's role in breastfeeding. Additionally, future interventions development may build upon this work by framing partner breastfeeding education in new ways that are tailored to the complexity of the supportive partner role.

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### Note

1. We recognize that family structures take many forms, including single parents, along with female, male, and nonbinary-identifying co-parents. The current literature review is focused on biological mothers with co-parent fathers, which aligns with the scope of the available study sample.

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