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New Mothers' Perceptions Of Breastfeeding, The Transition To Parenthood, And The Partner Alliance: A Grounded Theory Study

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NEW MOTHERS' PERCEPTIONS OF BREASTFEEDING, THE TRANSITION TO
PARENTHOOD, AND THE PARTNER ALLIANCE: A GROUNDED THEORY
STUDY

by

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A Dissertation

Submitted to the Graduate Faculty

of the

University of North Dakota

In partial fulfillment of the requirements

for the degree of

Doctor of Philosophy

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December
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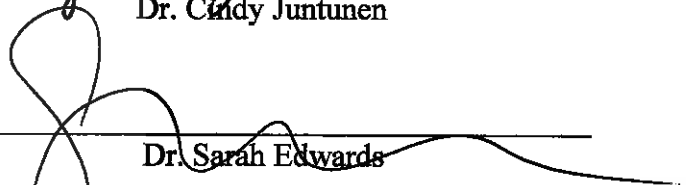
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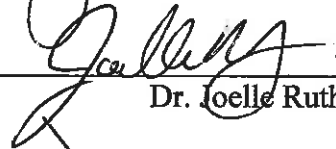
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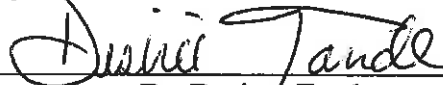
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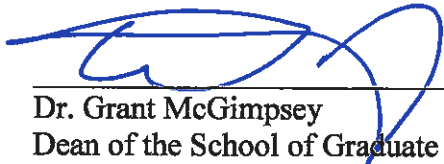


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This dissertation is being submitted by the appointed advisory committee as having met all of the requirements of the School of Graduate Studies at the University of North Dakota and is hereby approved.



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PERMISSION

Title: New Mothers' Perceptions of Breastfeeding, the Transition to Parenthood, and the Partner Alliance: A Grounded Theory Study

Department: Counseling Psychology

Degree: Doctor of Philosophy

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Jennifer A. Munch
November 22, 2016

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“To Molly and Scott”

ABSTRACT

The purpose of this study was to examine first-time mothers' perceptions of the interaction between their partner relationship, transition to parenthood, and breastfeeding. The study utilized the qualitative method of constructivist grounded theory (CGT) to achieve these means. Participants included eight primiparous, postpartum, and cohabiting and partnered mothers. Each participant was between 3 to 8 months postpartum when they completed a semi-structured 1.5 to 2 hour phone interview. They were asked questions related to their experiences with becoming new parents and breastfeeding, including changes, challenges, and overcoming barriers. They were also asked to share their views and feelings related to their partner relationship, including how parenthood and breastfeeding have impacted emotional and physical intimacy with their partners, as well as how the partner relationship has impacted breastfeeding. Lastly, the mothers shared about their decision to breastfeed, their perseverance, and their commitment to continuing breastfeeding. Following each interviews, the audio recordings were transcribed.

In line with CGT, data was then organized and analyzed with the following four steps: (a) assigning initial codes for each line of the transcript, (b) creating focused codes for each theme that emerged in the data using a constant comparison technique, (c) developing a theoretical model to explain how the couples in the study perceived the interaction of breastfeeding and the partner relationship, and (d) considering

existing theory in the literature and incorporating a particular model that supported the processes that were uncovered in the current study.

Through this method, a model was developed that explained the participants' experiences with the interaction of breastfeeding and the partner relationship. The components of the model included (a) getting on board: the decision to breastfeed, (b) holding on tight: perseverance through struggles, (c) focusing on the baby and teamwork, (d) role shuffling, (e) settling into the routine and roles, (f) nurturing the partner relationship, (g) feeling grounded, and (h) being present and responsiveness across systems. The Theory of Planned Behavior (Ajzen, 1991, 2011) was incorporated with these components to further support a model of how the partner alliance contributes to the mother's decision to initiate and continue breastfeeding.

A literature review of the study variables is included and explores the transition to parenthood, partner relationship functioning and satisfaction, and breastfeeding. In addition, limitations of the current study are addressed with recommendations for future research. Lastly, implications of the current study findings are explored, including considerations related to perinatal education, couples counseling, and peer and health professional support programs.

CHAPTER I

INTRODUCTION

In the past two decades, researchers have developed a substantial body of knowledge regarding the impact of having a baby on the relationship of first time parents (Lawrence, Rothman, Cobb, & Bradbury, 2010). Infant feeding is a primary focus of new parents as they attempt to navigate the many new and significant demands of caring for a new baby. However, within the transition to parenthood body of literature, what is less understood is the impact that breastfeeding the first baby has on the partner relationship. The purpose of this paper is to qualitatively explore the latter in order for parents, medical professionals, and counselors to better assist new families in creating an emotionally and instrumentally supportive and informed environment. The present study used Grounded Theory (GT) to explore the interaction between breastfeeding and the partner relationship in order to emphasize the lived experiences of new mothers, as well as to create a model to explain the interaction.

The experience of having a first child has been well-documented as an impactful event for parents (Lawrence et al., 2010). The transition to parenthood is a time in which couples attempt to learn how to manage many changes while caring for a new infant. A finding related to this that has been consistently demonstrated is the increased level of stress that couples experience following the birth of a first child. Though the introduction of a new family member is often an exciting time for parents, it has also been identified

as one of the most stressful life events one can experience (Cowan & Cowan, 2003; Dohrenwend, Krasnoff, Askenasy, & Dohrenwend, 1978).

Studies have also examined how this life event impacts relationships, particularly relationship satisfaction within partners. Several research studies suggests that relationship satisfaction reliably decreases throughout the transition to parenthood and gradually continues to decrease thereafter (e.g., Belsky & Pensky, 1988; Cowan & Cowan, 1995; 2000), until an increase in satisfaction during the empty-nest phase, the period of time when all children have moved away (e.g., Gorchoff, John, & Helson, 2008). These findings are not surprising given the suddenness and intensity required for caring for an infant. Though various factors are present in the transition to parenthood, a crucial element of the new parenting process there is particularly little understanding about is how infant feeding practices, and specifically breastfeeding, impacts the relationship during the transition to parenthood.

The act of breastfeeding is defined as “receiv(ing) breast milk direct from the breast or expressed” (World Health Organization [WHO], 2009). Breast milk is considered the undisputed optimal sustenance for infants for a variety of infant, maternal, and societal reasons. Benefits of breast milk for babies include lower incidence of respiratory, ear, and urinary tract infections within the first 2 years of life, and lower incidence of sudden infant death syndrome (SIDS) within the first year (WHO, 2007). The benefits of breast milk also extend to breastfeeding women’s health outcomes including lowered risk of diabetes, obesity and asthma (Gartner et al., 2008).

As a result of these and other findings that demonstrate the benefits of breastfeeding, the WHO (2007) recommends that mothers breastfeed until age 2 or

beyond. However, despite these recommendations, breastfeeding rates in the United States fall well short of this. As a result, recent government health initiatives and interventions have aimed to address improving breastfeeding initiation and duration rates (e.g., Healthy People 2020 (United States Department of Health and Human Services, 2012), the Baby-Friendly Hospital Initiative (WHO/United Nations Children's Fund [UNICEF], 1992)).

Perhaps as a result of enhanced programming, awareness and advocacy, recent years have seen a steady, gradual increase in breastfeeding rates. However, aside from the initiation rates, the statistics are still lag far behind from the Healthy People target goals (USDHHS, 2012). This suggests that the interventions and policies that have been implemented have potentially been positively influential on breastfeeding rates, but may be missing elements that might enhance their efficacy.

Historically, a potentially overlooked element in breastfeeding promotion and policies is the consideration of the non-breastfeeding partner in two parent families. Recent research indicates that male partner involvement in the breastfeeding relationship is a strong predictor of whether or not a woman decides to initiate, continue, or terminate breastfeeding. For example, women who perceive active and positive support from their partners had higher breastfeeding self-efficacy than those who reported ambivalent or negative partner support (Mannion, Hobbs, McDonald, & Tough, 2013). Another study suggests that women who breastfeed beyond 6 months attribute their ability to continue to the support of their partners (Guyer, Millward, & Berger, 2012). In addition, research indicates that perceived breastfeeding support is significantly related to exclusive breastfeeding duration (Ekstrom, Widström, & Nissen, 2003).

However, despite the increased research exploring partner support and breastfeeding, little is known about how breastfeeding impacts the couple relationship. Research that has looked at elements of the couples' relationship has focused on how breastfeeding influences the sexual functioning and intimacy of breastfeeding mothers and their partners. For example, a review by LaMarre, Paterson, and Gorzalka (2003) found that compared to women who are not breastfeeding, breastfeeding women are more likely to experience decreases in sexual functioning, particularly related to sexual desire. However, little is known about the impact this has on the couples' relationship beyond issues of sexual intimacy.

Though research indicates partner support is positively related to breastfeeding, and breastfeeding has implications on the sexual relationship, what is not known is the impact of breastfeeding on relationship dynamics and satisfaction of new parents. Despite the various implications breastfeeding has on couples, including sexual, emotional, physical, and cultural aspects of the romantic relationship, minimal research has attempted to explore this. Therefore, very little is known about the costs and benefits of breastfeeding on parents and the relationship. Despite the inherent intimacy of breastfeeding between parent and child, and the importance of intimacy within family dynamics (Mitnick, Heyman, & Smith Slep, 2009), no research has examined the impact of infant feeding on romantic relationship dynamics. As such, the purpose of the current study aims to fill this gap in the literature by uncovering how breastfeeding impacts processes related to relationship functioning and satisfaction during the postpartum period.

In addition, although research has examined the beneficial nature of partner support on breastfeeding initiation and duration, little has been uncovered about the actual behaviors that partners engage in to facilitate the breastfeeding relationship. It is also unknown how partner involvement and how the relationship with the partner impacts a new mothers' perceptions and experiences of breastfeeding. This knowledge is important for families to be aware of so that partners of breastfeeding mothers know how to best support their partner at various points of breastfeeding during the transition to parenthood. Therefore, this study also aimed to examine how relationship functioning and satisfaction impacts breastfeeding throughout the postpartum period.

Exploring the interaction of breastfeeding and relationship dynamics will advance an understanding of how breastfeeding impacts first time parents' relationships and vice versa. The purpose of this study is to investigate women's perceptions of the interaction between breastfeeding and relationship satisfaction and functioning. Little is known about these processes; therefore, constructivist grounded theory (CGT; Charmaz, 2006, 2014) methodology will be used. CGT is a qualitative approach that aims to develop a theory based on the lived experiences of individuals who have knowledge about the phenomena under study. Because the breastfeeding relationship originates with the mother and she is the expert of her breastfeeding experiences, her perspective will be the focus of this research. CGT methods will be particularly applicable in uncovering the breastfeeding and relationship experiences of women as it provides a foundation and procedure that can elicit both explicit and underlying experiences in order to develop a theory grounded in such experiences (Charmaz, 2006, 2014).

Grounded Theory is particularly applicable to counseling psychology for several reasons. Fassinger (2005) notes, that it is able to “integrates theory and practice in ways that few other approaches can boast” (p. 165) and as such exemplifies the scientist–practitioner model. It also provides flexible and structured analytic procedures that prioritizes focus on the subjective experience of participants as catalyst for developing theory, while also incorporating the social context.

Within qualitative research, one test of the validity of the research is the usefulness of the data and theory generated (Morrow, 2007). The implications of knowledge that could be gained from studying the interaction between breastfeeding and relationship functioning are many. For example, existing interventions such as the World Health Organization’s international Baby-Friendly Hospital Initiative (WHO, 2009) could incorporate psychosocial aspects of the breastfeeding relationship that are currently missing from its curriculum. In addition, prenatal and postnatal education classes could also address the benefits of attending to and maintaining relationship satisfaction while breastfeeding. These classes could also serve to prepare parents for how breastfeeding can impact the relationship by teaching participants about the changes and emotions they may experience, as well as teaching strategies that can be implemented to buffer potential negative or stressful outcomes.

This research may also contribute to the transition to parenthood and relationship satisfaction literature. Currently, such research does not examine breastfeeding as one of the key processes involved in accommodating a new child. Increased knowledge of how breastfeeding impacts day to day relationship functioning and satisfaction may protect

parents from the typical decline in satisfaction that has been observed in romantic relationship research (Mitnick et al., 2009).

Lastly, there are potential social implications of this study. Much of the research on breastfeeding originates from the medical and public health fields. Addressing breastfeeding from a counseling psychology lens can shed additional light on a topic that has historically been stigmatized for various reasons. Exploring breastfeeding as a psychosocial, cultural, feminist, and family issue may allow for novel aspects of the experience to be discovered. This may enhance understanding of the various processes related to breastfeeding which may serve to alleviate this stigma. Therefore, it is hoped that the current study can be another step in advancing breastfeeding as an issue that merits open discussion so that parents can gain needed support from one other as well as from outside the dyad.

CHAPTER II

LITERATURE REVIEW

The purpose of this literature review is to present a rationale for examining the interaction of breastfeeding and relationship satisfaction from the perspective of primiparous (first-time) mothers. In order to provide background for this rationale, the literature review discusses breastfeeding rates, benefits and disadvantages of breastfeeding and breast milk, and facilitators and barriers of breastfeeding. Following this, formal and informal sources of breastfeeding support and education are outlined and recent research focusing on male partners of breastfeeding mothers is presented. Research on partner involvement and support related to breastfeeding is also examined, as well as the transition to parenthood and its impact on partner relationship quality. Selected theories related to relationship quality and satisfaction, such role strain, relationship maintenance, and attachment theories are then reviewed. Lastly, research that has specifically studied breastfeeding and romantic relationship factors are discussed, as well related limitations and implications.

This literature review also demonstrates justification for the use of constructivist grounded theory (CGT) methodology for exploration of the current study's concepts. CGT is a qualitative research method that allows for researchers to capture the lived experiences of participants, and to use their words as basis for the development of a theory (Charmaz, 2006, 2014). An area of emphasis within CGT is for researchers to

continually revisit data in order to identify themes and uncover a theory based on the experiences of the participants, rather than to apply predisposed notions, assumptions, or hypotheses. As such, classic grounded theory methodology calls for the literature review to be completed following data collection, so as not to skew the bias of the researcher and thus limit the ability to make new discoveries (Glaser & Strauss, 1967). However, more recent grounded theorists have suggested that the literature review serves as a broad overview of the literature (e.g., Charmaz 2006; Corbin & Strauss, 2008). In addition, CGT suggests that the researcher have some experience or exposure to the topic and population under study. Therefore, the following literature review is intentionally not exhaustive and discusses select research and general issues related to breastfeeding, partner involvement and support, the transition to parenthood, and romantic relationships. Congruent with CGT, a subsequent literature review will be presented in the Discussion chapter as it relates to the emergent theory of the current study.

Breastfeeding

Breast milk is widely accepted as the optimal sustenance for infants. Most health professionals endorse exclusive breastfeeding through 6 months of age and partial breastfeeding through at least 1 year of age with supplementation of solid foods. The WHO (2007) recommends breastfeeding continue until age 2 or beyond, while the American Academy of Pediatrics (AAP; 2012) recommends “exclusive breastfeeding for about 6 months, followed by continued breastfeeding as complementary foods are introduced, with continuation of breastfeeding for 1 year or longer as mutually desired by mother and infant” (p. 827-828).

Infant Benefits of Breastfeeding

These recommendations are in place due to the numerous health benefits of breast milk for infants and children. Research indicates that breast milk is related to various favorable medical, developmental, and psychological outcomes (e.g., AAP, 2012). Several areas of medical research has found consistent empirical support for exclusive breastfeeding in the first 6 months of an infant's life (e.g., Bartick & Reinhold, 2010; Kramer & Kakuma, 2012; WHO, 2007). Exclusive breastfeeding is linked to lower incidence of respiratory, ear, and urinary tract infections within the first 2 years of life, and lower risk of sudden infant death syndrome (SIDS) within the first year (WHO, 2007). In an analysis for the American Academy of Pediatrics, Bartick and Reinhold (2010) note that if 90% of families in the United States adhered to the recommendation of 6 months of exclusive breastfeeding, over 900 infant deaths would be prevented. Furthermore, estimates by UNICEF (2011) state that 6 months of exclusive breastfeeding could prevent the deaths of 1.4 million children under age 5 in the developing world. The benefits of breast milk also influence adult health outcomes including lowered risk of diabetes, obesity and asthma (Gartner et al., 2005).

Maternal Benefits of Breastfeeding

In addition to the infant benefits of consuming breast milk, breastfeeding is also associated with maternal benefits. Breastfeeding contributes to postpartum weight loss and return to pre-gestational weight (Sámano et al., 2012) and decreases risk of breast and ovarian cancers (Gartner et al., 2005). In a study with postmenopausal women, increased duration of breastfeeding was linked to lower risk of hypertension, diabetes, hyperlipidemia and cardiovascular disease (Schwarz et al., 2009). Another potential

benefit for some women and families is that breastfeeding delays the return of menses following the birth of a child, and decreases incidence of repeat pregnancy (Gartner et al., 2005). Breastfeeding also appears to be linked to decreased incidence of postpartum depression (Haga, 2012; Watkins, Meltzer-Brody, Zolnoun, & Stuebe, 2011).

This may be related to research that suggests that breastfeeding enhances physical and psychological bonds between mother and child (Gartner et al., 2005). Lastly, recent research by Bartick et al. (2016) suggests that breastfeeding is an outright maternal health issue, noting that the costs of health problems related to suboptimal breastfeeding were 80% maternal versus 20% infant or child. This study projected that if 90% of mothers in the United States reached optimal breastfeeding rates, 2619 maternal deaths and 721 child deaths would be prevented each year (Bartick et al., 2016). They note that breastfeeding decreases maternal breast cancer, type 2 diabetes, hypertension, and heart attacks.

Economic and Community Benefits of Breastfeeding

Outside of the mother-infant dyad, breastfeeding has also been identified being beneficial for communities for economic and environmental reasons. For example, though there can be financial costs associated with breastfeeding (for example, if not covered by insurance, mothers may need to purchase a breast pump out of pocket), these costs are typically much lower compared to the cost of formula. Formula is a manufactured product “intended to meet the normal nutritional requirements of infants” (Koletzko et al., 2005) and is considered the sole alternative to breast milk. A calculation by Ball and Wright (1999) noted that families that breastfeed save over \$1200 per year on costs related to purchasing formula and \$331 on healthcare. On a more global scale, the

health benefits of breastfeeding reduces costs of healthcare. Bartick and Reinhold (2010) estimate that the United States could save \$13 billion per year on healthcare costs due to infant mortality, infant health, and childhood obesity if breastfeeding rates increase to the levels recommended by the United States Department of Health and Human Services (2012). More recent research by Bartick et al. (2016) states that 6 months of exclusive breastfeeding with an additional 6 months of breastfeeding supplemented by solid food would save over \$18.5 billion in costs related to premature deaths. Lastly, environmental benefits of breastfeeding have also been identified. The manufacturing, packaging, and transporting of formula is estimated to require around 110 billion BTUs (British Thermal Units) of energy per year (United States Breastfeeding Committee, 2002). In addition, 550 million formula cans that consist of 86,000 tons of tin are processed and discarded in landfills each year (Jeliffe & Jeliffe, 1978).

Disadvantages of Breastfeeding

Research has also investigated the disadvantages of breastfeeding. Particularly for the early weeks and months of an infant's life, feeding directly from the breast requires that a mother be with her child regularly throughout the day and night. This can be physically demanding and can prevent a mother from engaging in other tasks. A specific issue that has been explored is the impact of breastfeeding on women who desire to or need to return to or begin work outside the home. Though policies are established for some places of employment and some states, the time and space required for a mother to express milk with a breast pump, or to leave work to breastfeed, are not consistently available to all mothers (Abdulwadud & Snow, 2012). It can also be physically difficult for mothers who are recovering from a challenging labor, including a caesarian surgery

(Karlström, Engström-Olofsson, Norbergh, Sjöling, & Hildingsson, 2007), as well as mothers who experience postpartum depression (Watkins, Meltzer-Brody, Zolnoun, & Stuebe, 2011) to establish and continue breastfeeding. In addition, for most women, nipple pain, often related to a poor latch at the breast by the infant, is a common occurrence for women who attempt to breastfeed (Tait, 2000). Such pain can range from mild discomfort to excruciating pain and nipple and areola injury. Lastly, another potential disadvantage of breastfeeding is related to its impact on relations between family members. Research by Sherriff, Hall, and Pickin (2009) suggests that male partners may perceive that breastfeeding disrupts their ability to bond with a new infant, while Jackson (2002) noted that breastfeeding is linked to decreased sexual activity in couples.

Prevalence of Breastfeeding

As indicated, there are various benefits and disadvantages related to breastfeeding. In general, the benefits outweigh the disadvantages and health professionals and organizations strongly endorse breastfeeding above alternate feeding methods and substances (e.g., AAP, 2012; Centers for Disease Control and Prevention [CDC], 2013; WHO, 2009). However, despite the numerous benefits and the recommendations put forth by medical and health institutions, in the United States, breastfeeding is not the most common infant feeding method throughout infancy. In order to investigate and improve breastfeeding rates, the United States Office of Disease Prevention and Health Promotion oversees a program called Healthy People which aims to establish “science-based, 10-year national objectives for improving the health of all Americans” (USDHHS, 2012). The Healthy People 2010 reported that breastfeeding

initiation rates are meeting the targeted rates for the first time since the program was established in 1979. However, although breastfeeding initiation rates in the United States have increased from the lowest ever prevalence of 22% in 1972 to the current rate of 75% (CDC, 2013), rates of breastfeeding decrease dramatically for most mothers within days of delivery. In addition, the rates of duration are far from the set targets of 50% at the 6 month postpartum mark and 25% at the twelve month mark (USDHHS, 2012). In addition, the Healthy People 2010 report identified that exclusive breastfeeding rates also fell short of the goals of 40% at the 3 month mark and 17% at the 6 month mark (USDHHS, 2012).

In December 2010, Healthy People 2020 was published. The breastfeeding targets are compared to rates reported in 2007-2009 of babies born in 2006:

- Increase the proportion of infants who are ever breastfed from 74% to 81.9%
- Increase the proportion of infants who are breastfed at 6 months from 43.5% to 60.6%
- Increase the proportion of infants who are breastfed at 1 year from 22.7% to 34.1%
- Increase the proportion of infants who are breastfed exclusively through 3 months from 33.6% to 46.2%
- Increase the proportion of infants who are breastfed exclusively through 6 months from 14.1% to 25.5%

Additional targets include reducing formula supplementation within 2 days of birth, increasing workplace lactation policies, and improving healthcare facilities to be more conducive to supporting breastfeeding.

Each year, the CDC (2016) publishes a Breastfeeding Report Card that summarizes breastfeeding rates across all U.S. states and the District of Columbia and Puerto Rico. The most recent Breastfeeding Report Card, published in August 2016, states that rates continue to steadily increase: “among infants born in 2013, 4 out of 5 (81.1%) started to breastfeed, over half (51.8%) were breastfeeding at 6 months, and almost one third (30.7%) were breastfeeding at 12 months (CDC, 2016, p. 2). Rates are generally higher in the western half of the country, as well as the northeast. The Report Card further indicated that although overall there are “high breastfeeding initiation rates and continued improvement in breastfeeding duration, most states are not yet meeting HP2020 breastfeeding duration and exclusivity targets” (p. 2). They note that the high initiation rates suggest that most mothers want and try to breastfeed. However, many mothers do not continue breastfeeding as recommended past the 6 or 12 month mark which suggests that they “may not be getting the support they need, such as from healthcare providers, family members, and employers” and that “the early postpartum period is a critical time for establishing and supporting breastfeeding” (p. 2). The Report Card also addresses the increase of live births that occur in Baby-Friendly hospitals which jumped from 7.8% in 2014 to 18.3% (current) in 2016.

Breastfeeding Barriers

There are various reasons for these trends in breastfeeding rates. An abundance of research has attempted to uncover why rates of breastfeeding in the United States are low

compared to other developed countries. Research across disciplines, particularly within public health, nursing, and obstetrics, provides a wealth of information on factors that impact breastfeeding rates. For the sake of organization, this section is divided into two subsections, maternal barriers and cultural barriers. However, there is often an interaction between factors that prevent or hinder breastfeeding, especially with regards to how cultural influences impact maternal factors. The use of the term maternal barriers is not to suggest that the mother is deficient, but rather that these factors have been identified by researchers as being prevalent for some mothers. However, just as the personal is political, cultural context permeates these seemingly individual factors.

Maternal barriers. A meta-analysis by Dennis (2002) noted that decreased incidence and duration of breastfeeding is linked to low socioeconomic status, young age, non-Hispanic non-White demographic, lack of breastfeeding confidence, and negative attitudes towards breastfeeding. Another maternal barrier related to low breastfeeding rates is perceived milk supply limitations (Allen & Hector, 2005). This misperception is experienced by up to 50% of women, though only 5% of women have actual physiologically insufficient milk supply (Allen & Hector, 2005). Postpartum depression is also inversely related to breastfeeding (Dennis & McQueen, 2009). Women who have experienced or currently experience intimate partner violence are less likely to initiate breastfeeding, and those who do are more likely to discontinue within 4 weeks if the violence occurred during pregnancy (Silverman, Decker, Reed, & Raj, 2006). Cesarean section deliveries can also impede initiation of breastfeeding, depending on hospital practices (Rowe-Murray & Fisher, 2002).

A study by Li, Fein, Chen, and Grummer-Strawn (2008) explored mothers' perceptions of breastfeeding termination reasons by providing a list of previously identified barriers and asking participants to rank order importance. Half of the women selected perceived insufficient milk supply as being the most important. Other top-rated reasons were perceived lack of interest by the infant or self-weaning, infant biting, and lack of education and support.

In a qualitative study by Guyer and colleagues (2012), mothers reported the following challenges as being significant in the cessation of breastfeeding: latch problems, pain, feeling vulnerable, and lack of breastfeeding education. A review of breastfeeding literature by Milligan, Pugh, Bronner, Spatz, and Brown (2000) noted that fatigue was the most frequently reported reason that mothers choose to stop breastfeeding. These researchers also identified low SES, other children, young age, and limited support and knowledge as factors that contribute to the termination of breastfeeding.

Cultural barriers. On a more societal scale, the literature has identified cultural barriers that can hinder breastfeeding such as medical staff and institutional biases, lack of access to resources, and cultural values and perceptions of the female body (Obermeyer & Castle, 1996; Smith, 2008). Another barrier that is especially relevant to families in the United States is the brief duration of leave granted to new parents which is noted to be the worst of any developed country (Murtagh & Moulton, 2011). In fact, the United States received the lowest score of all developed nations on Save the Children's *Breastfeeding Policy Scorecard* (STC, 2012), a review that evaluates maternity leave laws, breastfeeding breaks at worksites, and Baby-Friendly hospitals. The United States

is the only country that does not mandate paid leave following childbirth (STC, 2012). The absence of job security, paid maternity leave, and breastfeeding-friendly workplace policies can compromise mothers' ability to continue breastfeeding if they are forced to or choose to return to work outside the home (Murtagh & Moulton, 2011).

Another important cultural artifact that is detrimental to breastfeeding rates is related to alternate infant feeding methods. Research indicates that the prevalence of formula advertisements and goods has a substantial impact on breastfeeding attitudes, initiation, and duration. For example, Kaplan and Graff (2008) investigated the impact of formula development and marketing on breastfeeding rates. When formula was invented in the 1860s, it was marketed as offering better nourishment than breast milk. In addition, it was initially advertised as requiring instruction from physicians for preparation. This meant that women could only use it if they met with their physicians which led to increased income for physicians (Kaplan & Graff, 2008). Formula companies also sponsored conferences on infant feeding, and distributed free samples to doctor's offices and hospitals to enhance visibility with medical providers (Greer & Apple, 1991). In the 1960s, formula company tactics faced backlash following infant deaths in developing countries related to formula use (Jeliffe & Jeliffe, 1978). Though advertising regulations soon followed, formula companies continue to use health institutions as a major source of distribution and marketing (Greer & Apple, 1991). In 1981, the WHO developed the "International Code of Marketing of Breast-Milk Substitutes" which restricts formula marketing to the public and within hospitals, and free samples. While 165 of 199 countries have enacted the code as a national measure or legislation, the United States has not done so (Grayson, 2016). Research by Howard and colleagues (2000) indicated that

women who received infant feeding materials developed by formula companies at prenatal appointments had significantly lower initiation and duration rates of breastfeeding compared to women who had not been given such materials. Hospital practices that are not medically indicated, such as supplementation with formula soon after birth, can impede the mothers' ability to build her milk supply at a crucial time and thereby be a barrier to initiation of breastfeeding (e.g., Parry, Ip, Chau, Wu, & Tarrant, 2013). Other studies have also found that women who are given formula samples upon discharge from the hospital following the birth have lower breastfeeding continuation rates (e.g., Kent, 2006; Rosenberg, Eastham, Kasehagen, & Sandoval, 2008).

Breastfeeding Facilitators

In sum, there is a vast range of challenges and barriers women face that can impact their ability, motivation, and desire to breastfeed. Though not all of these factors can be overcome, many types of interventions and resources have been developed with the goal of decreasing barriers related to breastfeeding and ultimately increasing breastfeeding rates. These interventions include formal breastfeeding education and resources, and formal and informal peer support. Though there has been extensive research investigating the development and efficacy of such resources, select research is outlined briefly in the upcoming section.

Formal interventions. As mentioned at the outset of this chapter, recent government initiatives have been instituted in light of the concern of low breastfeeding rates. An example of a program that targets low to moderate income families is the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC, 2014). WIC offers food vouchers and resources to families from pregnancy through age 5 for

children who are considered “nutritionally at risk” (related to medical or dietary risk) and who meet income eligibility (at or below 185% of the poverty line). In 2015, eight million women and children in the United States and United States territories participated in WIC services (WIC, 2016).

WIC has increased its active advocacy of breastfeeding sharply over the last several years in the form of enhanced food packages for women who breastfeed, staffing of International Board Certified Lactation Consultants (IBCLCs) and the implementation of peer counseling support programs (WIC, 2014). Some WIC offices also provide equipment that can assist in breastfeeding such as breast pumps, nursing covers, breast pads, and milk storage accessories. However, Kent (2006) posits that WIC has had a limited impact on overall breastfeeding rates because of its limited reach. In fact, up until fifteen years ago, WIC’s stance on breastfeeding was more neutral than positive, and this, in addition to their provisions of formula to low- income mothers, was perceived as contributing to low rates of breastfeeding, rather than improving it (Kent, 2006).

Another resource related to government policy is the Baby-Friendly Hospital Initiative (WHO/UNICEF 1992, 2009). The Baby-Friendly Hospital Initiative is an international movement to enhance maternal and infant health by providing training and guidelines to implement practices that encourage and sustain breastfeeding in hospitals and birthing centers. Facilities that undergo Baby-Friendly Hospital Initiative training and adopt the evidence-based “Ten Steps to Successful Breastfeeding” are designated “Baby-Friendly” and are given tools and materials to support breastfeeding. Examples of the ten steps include, “help mothers initiate breastfeeding within one hour of birth” and “foster the establishment of breastfeeding support groups and refer mothers to them on

discharge from the hospital or birth center” (WHO/UNICEF 2009, p. 3). Over 15,000 facilities in 134 countries have been designated as Baby-Friendly (UNICEF, 2014). Outcome research on the BFHI by DiGirolamo, Grummer-Strawn, and Fein (2008) indicates that mothers who birthed at hospitals that did not enforce any Baby-Friendly practices were 13 times more likely to terminate breastfeeding before 6 weeks postpartum compared to mothers who birthed at hospitals that implemented Baby-Friendly practices. Another study by Perrine, Scanlon, Li, Odom, and Grummer-Strawn (2012) also suggests that Baby-Friendly practices such as attempting breastfeeding within one hour of birth and absence of supplemental feeding and pacifiers is related to increased rates of breastfeeding initiation.

A type of formal intervention available to some women in the perinatal phases are education programs provided at hospitals and clinics. These classes often offer basic information related to pregnancy, childbirth, and childcare for a fee. These programs often include a breastfeeding skills component taught by an IBCLC. In addition, some hospitals and clinics provide follow-up drop-in courses or appointments where women can visit with an IBCLC in a one-on-one or group setting. Thurman and Jackson Allen (2008) reviewed studies related to breastfeeding support and found that contact with IBCLCs and breastfeeding duration are positively correlated. In addition, doula care is associated with breastfeeding initiation and increased breastfeeding rates at 6 weeks postpartum (Nommsen-Rivers, Mastergeorge, Hansen, Cullum, & Dewey).

Formal peer support programs. In addition to formal education interventions, social support has also been linked to successful breastfeeding outcomes. Peer programs such as La Leche League International support groups have been shown to be related to

increased breastfeeding rates (USDHHS, 2012). These programs emerged in the 1980s and are typically based in the community as a means to generate support and education for mothers interested in breastfeeding (Rossman, 2007). In fact, the WHO recognizes La Leche League group presence as a marker of community breastfeeding support as documented in its Healthy People reports (WHO/UNICEF, 2009).

Informal social support. Research also indicates that the support of partners, friends, and family can be more important and influential than formal sources of support (Dennis & McQueen, 2002; McInnes & Chambers, 2008). Forste and Hoffmann (2008) argue that educating members of the support system of a potential or current breastfeeding mother is crucial to increase initiation and duration rates. They note that this significant influence is primarily due to women having much more frequent contact with informal sources of support as compared to formal sources of support. This type of support is especially beneficial for low income populations who may have less access to formal interventions because of factors such as difficulty with transportation alternate childcare options. Social support related to breastfeeding provides individuals with confidence, a sense of community, and knowledge (Kaunonen, Hannula, & Tarkka, 2012). Recently, the importance of the involvement partners has emerged as an area of focus in the aim to increase breastfeeding rates and this will be examined in the upcoming section.

Partner Involvement in Breastfeeding

It is important to note that the research related to parenting, particularly in the medical disciplines, often fails to acknowledge the heteronormative biases of society and the researchers. This heteronormative mindset is so prevalent that the research described

rarely identifies sexual orientation or gender of the partner. As such, it is assumed that the research, unless otherwise noted, is with cisgender females in heterosexual relationships with cisgender male partners. Though researchers in counseling and psychology are more likely to utilize inclusive language and to intentionally examine such problematic biases, much of breastfeeding research is grounded in the nursing, public health, and medical fields where there is currently less recognition of the heteronormative presumptions.

Regardless of sexual orientation or gender identification, it is assumed that partners of breastfeeding mothers play a substantial role in breastfeeding. Studies show that partner attitudes and perceived support are related to mothers' breastfeeding attitudes, initiation and duration. For example, women who perceive their partners to be active in supporting their breastfeeding efforts have higher breastfeeding self-efficacy than women who perceive their partners to be ambivalent about breastfeeding (Mannion et al., 2013). In addition, research indicates that fathers' perceptions of their own support of breastfeeding influences maternal confidence and satisfaction with breastfeeding (Sherriff, Hall, & Panton, 2013). Perceptions of breastfeeding support of each member of the parent dyad has been addressed in the literature and will be explored in further detail below.

Maternal perceptions of partner support. A number of studies have examined maternal perceptions of partner support and how it relates to breastfeeding attitudes, initiation, and duration. For example, a cross-sectional study by Mannion and colleagues (2013) investigated perceptions of partner support of new mothers. Seventy-six mothers completed the Breastfeeding Self-Efficacy Scale (BSES; Dennis & McQueen, 1999) and the Hill and Humenick Lactation Scale (HHLS; Hill & Humenick, 1996), a measure that

assesses commitment and satisfaction related to breastfeeding. Women were also asked “Do you feel supported by your partner to breastfeed – why or why not?” and “How do you think your partner feels about breastfeeding?” Coding resulted in two categories of answers: ‘active/positive’ and ‘ambivalent/negative’. Results indicated that women who reported active/positive support had higher breastfeeding self-efficacy than those who reported ambivalent/negative support. Responses that were categorized as ambivalent/negative included partner displays of being indifferent or critical of breastfeeding (Mannion et al., 2013).

Another study (Ekstrom, Widström, & Nissen, 2003) examined retrospective perceptions of partner support in a sample of Swedish new mothers. A total of 488 heterosexual mothers completed questionnaires at 9-12 months postpartum related to breastfeeding history, confidence, and support. Results showed that for both primiparous and multiparous mothers, perceived breastfeeding support was significantly related to exclusive breastfeeding duration. In addition, the mere presence of the partner immediately following labor was also significantly related to the duration of both exclusive breastfeeding and total breastfeeding duration in primiparous mothers. Another interesting finding is that for all mothers, feelings of confidence related to breastfeeding duration at 6-12 months postpartum was related to confidence in partners during labor and delivery and perceived breastfeeding support (Ekstrom, Widström, & Nissen, 2003). These results suggest that early partner presence is a factor in later perceptions of partner support, and that partner support facilitates breastfeeding.

The role of the partner in breastfeeding was also demonstrated by Guyer and colleagues’ (2012) qualitative exploration of heterosexual mothers’ breastfeeding

experiences. Their findings revealed that women who breastfed beyond 6 months identified their partners as the primary influence in their ability to do so. An example of the support they received from partners was encouragement to do what they believed was right while faced with discrepant information related to breastfeeding. Conversely, mothers who had terminated breastfeeding prior to 1 month postpartum reported experiences such as partners discouraging breastfeeding and perceived jealousy of the mother-infant bond (Guyer et al., 2012).

Partner perceptions of breastfeeding. Historically, the perspective of partners of breastfeeding mothers has not been addressed in research. However, as studies uncover the significance of partner involvement as a factor in breastfeeding rates, recent research has focused on the role of the partner. Studies assessing partner perceptions of breastfeeding have demonstrated that fathers' views of their role within the breastfeeding family impacts mothers and breastfeeding rates. For example, Datta, Graham, and Wellings (2012) interviewed 14 heterosexual expectant and new fathers whose partners were considering or had decided to breastfeed. Participants were asked to discuss their perceptions of their role in breastfeeding. Results indicated that fathers believed their role was to support the mother's decision to breastfeed as well as to provide emotional and practical support to their partners throughout the duration of breastfeeding (Datta et al., 2012).

Another study by Tohotoa et al. (2009) more closely examined how fathers conceptualized emotional and practical breastfeeding support through a qualitative exploratory design. Researchers asked 76 heterosexual participants to identify how they conceptualized breastfeeding support. Data collection was conducted through focus

groups with mothers, while fathers engaged in a focus group, individual interviews, and an online survey. Findings suggested that fathers impact the breastfeeding process on several levels. Analysis of mothers' responses uncovered three themes related to partner support: anticipating needs and actively helping with tasks, encouraging mothers to do their best, and expressing and displaying commitment to breastfeeding. Analysis of fathers' responses identified three themes related to the desire to be involved in breastfeeding: wanting more information, learning the role, and being an advocate (Tohotoa et al., 2009).

Findings from a pilot study by Sherriff and Hall (2011) supported the conclusions of the Tohotoa et al. (2009) study. Researchers administered eight in-depth interviews to fathers of diverse socioeconomic status in heterosexual relationships. Results indicated that fathers are interested in breastfeeding and want to be more involved with preparing for and supporting breastfeeding. The fathers in this study also noted a desire for more relevant and accessible information about the benefits of breastfeeding as well as more education about ways they can provide practical support to their partner. These results suggest a need for breastfeeding interventions to involve fathers, to address the perspective of partners, as well as to offer information and resources on how partners can support mothers.

A study by Mitchell-Box and Braun (2012) also uncovered partners' desire to be informed about and be involved with breastfeeding. This study examined heterosexual males' perceptions of breastfeeding using grounded theory. Fourteen partners of low-income expectant and new mothers were recruited through WIC clinics in Honolulu, HI and asked about their attitudes, knowledge, and feelings about breastfeeding. Results

indicated that all participants identified the following perceptions: appreciation of the health benefits of breastfeeding, belief that breastfeeding is natural, empathy toward the efforts of their partners, lack of involvement in the feeding decision process, belief that formula feeding is more convenient than breastfeeding, and discomfort with breastfeeding in public. Implications of this study suggest that involving partners in breastfeeding interventions should expand beyond practical information in order to address the dyadic relationship and both parents' perceptions and beliefs related to breastfeeding. Such programs would enable couples to obtain information about how they can support one another, as well as how to address concerns and conflicting expectations.

Recent research by Sherriff and colleagues (2013) emphasizes the need to uncover processes that underlie support. This study utilized a concept analysis method with heterosexual couples to investigate and conceptualize partner breastfeeding support. Following an extensive literature review and interviews with new parents, they determined five categories of partner support: knowledge, positive attitude, involvement in the decision-making process, practical support, and emotional support. Specific aspects of each categories is as follows. The knowledge factor included behaviors such as vocal advocacy of breastfeeding, interactions with health professionals, and alleviating confusion about contradictory breastfeeding information. The positive attitude category reflected a perception of cultural acceptance of breastfeeding and health professionals' inclusion of fathers as an important member of the breastfeeding family. The decision-making factor identified the father's validation of the mother's decision to breastfeed as well as involvement in other decisions related to feeding. Practical support was identified as the father's contribution to household tasks and childcare responsibilities, attending to

the mother's needs while breastfeeding by engaging in tasks such as bringing her water, and offering pragmatic advice about breastfeeding problems. Lastly, within the emotional support category, display of pride and satisfaction in establishing breastfeeding, physical presence of the father, and displays of non-sexual affection and encouragement were recognized as breastfeeding support factors (Sherriff et al., 2013).

Breastfeeding interventions for parents. Indeed, based on the research that demonstrates the importance of including partners in the breastfeeding relationship, breastfeeding interventions have begun to include or even target partners. Educators and health professionals have recognized that increasing involvement and knowledge of partners can facilitate support, and thus potentially increase breastfeeding rates.

An early example of an informational program that included male partners was developed and tested by Susin and Giugliani (2008) in southern Brazil. Researchers implemented a controlled clinical trial to measure the impact of partner inclusion in a breastfeeding education class in a maternity hospital. Participants consisted of 586 heterosexual couples divided into three approximately equal groups: a control group, a group with only mothers exposed to the intervention, and a group with both parents exposed to the intervention. Researchers also measured breastfeeding rates within the first 6 months. Results indicated that partner involvement was positively related to exclusive breastfeeding rates, though it did not appear to have an impact on the rates of “any breastfeeding” (defined as any amount of breastfeeding). An unexpected finding is that compared to families in which only the mother was exposed to the intervention, breastfeeding rates were lower for families in which the father was exposed to the intervention, and had less than 8 years of education. This suggests that not all partner

involvement is beneficial, though the study did not ascertain what may have contributed to this finding. Overall, the research has not investigated how relationship dynamics influence breastfeeding. However, an area that has received considerable attention in the literature is how the partner relationship impacts the experience of having a child.

Transition to Parenthood and Relationship Satisfaction

The arrival of a new child brings about many changes in the lives of a couple. In addition to taking on the task of feeding an infant, new parents must also manage significant changes in their home, work, and social lives throughout the postpartum period. The literature has coined this period of time the “transition to parenthood” (Carter, 1965; Rossi, 1968). For many new parents, issues such as reduced sleep, disruption of routine, and the attempt to establish feeding are just a few of the challenges present following the birth of a child. The sudden onset of these issues can serve to exacerbate these challenges. As such, the transition to parenthood is a time in which couples attempt to quickly assess, learn about, and react to and manage many changes while caring for a new infant. Thus, though the introduction of a new family member is often an exciting time for parents, it is also identified as one of the most stressful life events one can experience (Cowan & Cowan, 2003; Dohrenwend, Krasnoff, Askenasy, & Dohrenwend, 1978). In addition, many studies indicate that romantic relationship quality and satisfaction steadily decline following the birth of a child (e.g., Belsky & Pensky, 1988; Cowan & Cowan, 1995, 2000).

Mitnick et al. (2009) conducted a meta-analysis of studies that examined relationship satisfaction during the transition to parenthood. After completing a literature search using combinations of the following terms: “transition,” “parenthood,”

“parenthood status,” “first time parent,” “relationship satisfaction,” “marital satisfaction,” and “marital relations,” 41 studies met criteria for inclusion. Of these studies, 37 assessed relationship satisfaction before and after the birth of a first child and four studies assessed relationship satisfaction in childless couples before and after their marriage. Analyses showed small to moderate declines in relationship satisfaction for couples from pregnancy to 14 months postpartum. However, an unanticipated finding was that the four studies that included childless couples revealed comparable declines in relationship satisfaction. These results suggest that relationship satisfaction decreases over time for childless couples and parents, and not only during the transition to parenthood. Mitnick and colleagues (2009) note that although stressors related to the transition to parenthood may contribute to a decline in relationship satisfaction, these declines may have occurred regardless of the presence of a new child.

In their meta-analysis, Mitnick et al. (2009) describe limitations typically present in transition to parenthood studies. A common occurrence is that recruitment of such studies is typically during pregnancy which is often a time of excitement and optimism related to expecting a child. This is also a period of time rife with societal expectations to be joyful which may also induce impression management. As such, in many transition to parenthood studies, the baseline measure of relationship satisfaction is inflated. The prenatal period is also a time that parents are susceptible to cognitive dissonance: overstated levels of relationship satisfaction may be reported due to the hope and investment that one’s partner is both a high quality partner and parent-to-be. The authors of this meta-analysis also note that measures frequently used in transition to parenthood studies, such as the Dyadic Adjustment Scale (Spanier, 1976) and the Marital Adjustment

Test (MAT; Locke & Wallace, 1959) may not accurately capture relationship satisfaction. Huston and Holmes (2004) argue that these measurements emphasize behavioral and cognitive aspects of relationships, rather than global satisfaction. As a result, they purport that supposed declines in relationship satisfaction may simply be a result of behavioral changes that are required following the addition of a child. The authors recommend the use of scales that have been verified by item response theory analysis, such as the Couples Satisfaction Index (Funk & Rogge, 2007) to measure relationship satisfaction.

A recent study by Mortensen, Torsheim, Melkevik, and Thuen (2012) investigated women's perceptions of relationship satisfaction during the transition to parenthood using a cohort design in Norway. Participants were 71,504 heterosexual women who were cohabitating, married or non-married. Prospective longitudinal data was collected 6 months before the expected due date of the baby and at three more time points over the next 2 years. Researchers administered a revised version of the Marital Satisfaction Scale (Blum & Mehrabian, 1999) to investigate relationship satisfaction, and asked whether or not the pregnancy was planned. Results revealed that both the non-married and married groups experienced similar decreases in relationship satisfaction throughout the transition to parenthood, but the non-married group's baseline satisfaction rate was lower. Therefore, along with the aforementioned meta-analysis, these findings support the notion that relationship satisfaction declines across couples of varying relationship and co-habiting statuses and that relationship satisfaction measures may not adequately capture differences across couple types.

Factors that may influence relationship satisfaction and the transition to parenthood experience are the attachment style of couples and the quality of the parenting alliance. Attachment style will also be discussed in the upcoming close relationships research section. It is defined as an orientation toward others that results from early experiences in close relationships, particularly with caregivers, that influences “a person's expectations, emotions, defenses, and relational behavior” (Bartholomew & Shaver, 1998, p. 25) in subsequent close relationships. A wealth of research has been conducted on how attachment styles and relationship satisfaction are related (e.g., Hammond & Fletcher, 1991; Kachadourian, Fincham, & Davila, 2004). A study based in Quebec examined the constructs of adult attachment, relationship adjustment, and the co-parenting relationship with 151 francophone and anglophone heterosexual couples (Bouchard, 2014). Couples were recruited through hospital prenatal classes and completed paper questionnaires in person or via mail during their third trimester and at 6 months postpartum. Findings suggest that for both men and women, postpartum perceptions of relationship quality mediated the association between prenatal insecure attachment and postpartum perceptions of co-parenting quality. In addition, men with prenatal insecure attachment had poorer relationship adjustment overall (Bouchard, 2014). Limitations of the study include a small sample size, while a strength of the study is its longitudinal design. These findings suggest that attachment orientation has a bearing on perceptions of relationship quality during the transition to parenthood. As such, factors related to attachment, such as expectations and communication styles, should be addressed in parenting support and education interventions.

Work by Ahlborg and Strandmark (2006) also examined participants' relationship quality at the 6 month postpartum mark. They utilized qualitative methods and a large sample size to investigate 535 Swedish first-time parents' perceptions of the quality of their romantic relationships. Inductive qualitative content analysis of two open questions, "Please describe what you think could be the main reasons for the way you experience your intimate relationship right now (whether positive or negative)." and "Have you taken any steps to try to change the situation and, if so, what?" was conducted. Results indicated four methods of coping that affect relationship quality in the transition to parenthood: adjusting to the parental role (e.g., mutual encouragement), intimacy (e.g., sharing emotional or sexual experiences), communication (e.g., reciprocal verbal and non-verbal actions), and external assistance (e.g., seeking social support). The authors concluded that parenting interventions should aim to teach coping skills related to both parenting and relationship factors, such as healthy communication and intimacy (Ahlborg & Strandmark, 2006).

In addition to coping and parenting skills, research has also investigated how partner support influences relationship satisfaction and the transition to parenthood. For example, Salmela-Aro, Nurmi, Saisto, and Halmesmaki (2010) sought to examine how paternal support of personal goals influenced relationship satisfaction during the transition to parenthood. Two hundred and forty-six heterosexual married and/or cohabiting Finnish women were recruited through prenatal appointments. They were asked to complete questionnaires regarding personal projects, spousal support, and relationship satisfaction early in pregnancy, 1 month before their expected due date, and 3 months postpartum. Analyses revealed that the primiparous women in the sample

indicated a cumulative cycle of goal-related partner support and relationship satisfaction, such that partner support of goals stated early in pregnancy predicted higher relationship satisfaction just before the birth. For the multiparous women, only relationship satisfaction predicted goal-related support at later time points. Results also revealed that both groups of women perceived low partner support for goals related to their individual self (such as goals of achievement), and perceived high partner support for goals related to the relationship or family (Salmela-Aro et al., 2010).

These findings illustrate the need for research to examine specific types of partner support, as partner support appears to vary depending on the circumstances, the target, and intention of the support. This seems to be true even when partner support is represented by one construct such as goals as demonstrated in the aforementioned study. This further points to the importance of developing parenting and breastfeeding interventions that consider various aspects of the partner relationship, rather than only tending specifically to parenting and breastfeeding. For example, partners may be more motivated to support their pregnant partners' goals with the knowledge that doing so may contribute to maintaining or increasing relationship satisfaction. In addition, facilitators of such programs could help couples explore their individual goals and reframe them as partner or family goals in order to elicit partner support and teamwork. For example, a mother who has the "individual" goal of breastfeeding her baby could be encouraged to consider this a family goal, and the couple could explore the implications and expectations together.

In addition to the role of goals in relationship satisfaction, Chong and Mickelson (2016) used a cross sectional and longitudinal design to examine the mediating role of

partner support in perceived workload fairness and relationship satisfaction for 92 heterosexual, new parents. Specifically, they investigated how childcare responsibilities, perceived emotional partner support, and negative partner interactions influence relationship satisfaction. Results revealed that at 9 months postpartum, mothers' perceptions of fairness of household tasks and childcare responsibilities was related to relationship satisfaction through the mediated variable of perceived emotional partner support. In addition, negative interactions between the partners mediated the relationship between mothers' perceptions of the fairness of childcare distribution and relationship satisfaction, both concurrently and longitudinally throughout the transition to parenthood (Chong & Mickelson, 2016). Overall, the findings indicate that emotional spousal support and negative spousal interactions must be considered when examining relationship satisfaction. This further emphasizes the need to examine the processes in romantic relationships in order to identify how couples can facilitate maintenance and improvement in relationship satisfaction while managing parenting tasks.

Howard and Brooks-Gunn (2009) also investigated support in the transition to parenthood with married and unmarried heterosexual couples. Their longitudinal study measured 2172 parents' perceptions of partner support at various times during the first 5 years after the birth of a first child. Parents were asked about perceived emotional support and relationship status at each time. Results suggest that mothers and fathers both perceive that partner support is high at birth followed by a steady decline. In addition, perceptions of support at 1 year predicted whether or not a relationship would end before the 5 year mark. Findings also showed that married couples have more positive

trajectories than unmarried couples: they reported higher levels of support and less decline of support overall (Howard & Brooks-Gunn, 2009).

Though the large sample size is a strength of this study, a limitation is that only the perceived level of emotional support was assessed and emotional support was not described or defined. Given that the transition to parenthood is a period of time with many changes, it is likely that the utility different types of emotional partner support varies over time and across circumstances. In other words, certain types of partner support are likely to be most efficacious at certain time points. For instance, verbal encouragement is a type of emotional support that is frequently support and it would be beneficial for parents to know when and how it is the most effective. For example, should it be emphasized immediately following the birth, when levels of unpredictability and novelty are high, or at 3 months postpartum when routines may have stabilized, but the couple have had little time and energy to devote to the relationship.

Research that has explored which types of partner support are most valuable has attempted to measure partner support outcomes. For example, Shapiro, Gottman, and Carrere (2000) uncovered factors that safeguard against decline in relationship satisfaction following the birth of heterosexual married couples' first children. Researchers labeled the mutual support "marital friendship," and assessed its levels over 6 years, from the beginning of marriage through the transition to parenthood and beyond. The final analysis included 43 couples who eventually became parents during the study and 39 who did not and were thus designated the control group. Researchers used the Oral History Interview (OHI; Krokoff, 1984) to ask couples about their relationship history, changes, and philosophies during the first year of marriage and annually

thereafter. They also completed the MAT (Locke & Wallace, 1959) each year. Couples who had a child also completed the MAT 6 months into the pregnancy and 3 months following the birth.

Results of the study revealed several factors that predicted stability, increase, and decline in relationship satisfaction. Sixty-seven percent of mothers reported experiencing relationship satisfaction decline while 33% experienced stable or increased satisfaction. Women who became mothers also experienced a steeper decline in relationship satisfaction compared to women who did not become mothers. However, mothers had higher initial relationship satisfaction at the outset of the study, before they became mothers. The lowest levels of relationship satisfaction were reported by mothers one year or more after the birth. Factors that predicted stable maternal relationship satisfaction included paternal fondness and admiration toward the partner, as well as paternal awareness. Paternal awareness referred to how a male partner responded to and elaborated on what their partner expressed during the OHI (Krokoff, 1984). Maternal relationship satisfaction was also predicted by maternal awareness. Regarding the factors that related to decreased maternal relationship satisfaction, paternal negativity toward partners, disappointment in the relationship, and perceiving life as chaotic predicted these declines. The researchers recommend that future studies investigate how relationships can increase resiliency so that couples can develop and strengthen protective factors (such as paternal fondness, paternal admiration, and paternal and maternal awareness) prior to and during stressful events such as the transition to parenthood (Shapiro et al., 2000).

Limitations of the Transition to Parenthood Research

As noted previously, a common problem with the transition to parenthood literature in general is the timing of the baseline measure of relationship satisfaction. Given that it is impossible to control whether or not couples who plan to conceive or are pregnant have higher baseline rates of relationship satisfaction, it is difficult to conclude that the transition to parenthood itself decreases relationship satisfaction. In addition, in light of the research that demonstrates that relationship satisfaction declines in all relationships over time (e.g., Mitnick et al., 2009), it may be more effective for researchers to examine the specific factors that contribute to dissatisfaction. For example, for couples with infants, investigating processes related to infant feeding methods may uncover aspects that facilitate or buffer against decline in relationship satisfaction.

A review of the transition to parenthood literature by Lawrence and colleagues (2010) also offers suggestions for future research based on the methodological flaws of the existing research. With regard to maximizing internal validity, they state the need for improved attentiveness to the following areas: controlling sources of variability in samples and measures (e.g., duration of relationship, ages of child), selection of appropriate control groups (e.g., assessing if childless couples are childless by choice or otherwise, assessing if pregnancies were planned or unplanned), and conducting studies that measure pre-pregnancy relationship satisfaction and functioning. The authors also note that most existing studies are limited in their external validity because they consist of heterosexual, white, married couples (Lawrence et al., 2010).

Close Relationship Theories

In addition to relationship satisfaction and the transition to parenthood research, there are many theories that have attempted to conceptualize close or romantic relationships. Given that a key aim of the current study is to explore the day-to-day relationship dynamics of the breastfeeding couple, such literature is relevant to this project. However, in line with CGT approach, only an overview of the close relationship literature is presented here. According to CGT methodology, delaying a more intensive literature review enables researchers to be grounded in their data and participants' experiences, rather than the presuppositions found in the literature. Depending on the current study's findings and emergent theory, a more thorough review applicable and alternate theories will be addressed in the Discussion chapter. Nonetheless, to provide a context for this relevant area of research, a brief review of selected close relationships literature is presented in this section, including theories of role strain, relationship maintenance behaviors, and attachment.

Role Strain

Role strain theory has been used to explain changes in romantic relationships and is particularly relevant to the transition to parenthood. Role strain is the challenge of attempting to fulfill role obligations (Bulcroft & Bulcroft, 1993; Burr, Leigh, Day, & Constantine, 1979). For example, research by MacDermid, Huston, and McHale (1990) found that maintaining the quality of the romantic relationship during the transition to parenthood necessitates couples to reevaluate and renegotiate their roles. Their research indicates that couples who are unable to do this experience a decrease in relationship satisfaction. Butt (1999) examined how the introduction of breastfeeding requires couples

to make adjustments within their relationships. Burr and colleagues (1979) posit three predictors of role strain that Butt (1999) notes are relevant to breastfeeding couples. The first is that the greater activity a role requires, the greater the strain experienced. This is certainly experienced by couples during the transition to parenthood when they add the role of a parent to their existing role of a partner. A second predictor of role strain is that the greater the incompatibility of roles, the greater the strain. This is particularly relevant to breastfeeding which is an activity that can overlap and contradict with women's existing roles. Depending on the women's values and that of her culture, breastfeeding may potentially conflict with roles such as being a sexually intimate partner, being an employed individual, and being an autonomous individual. Lastly, the third predictor of role strain is that the greater the diversification of roles, the less consensus there is of expectations, and the greater the strain. This predictor is especially relevant to the diverse and uncertain roles that the transition to parenthood brings. For example, the task of feeding an infant, which can be complicated to establish and maintain for many primiparous couples, demands that parents undertake a role that is initially unpredictable and unfamiliar (Burr et al., 1979).

Relationship Maintenance Theory

A second theory related to close relationships and relationship satisfaction is relationship maintenance theory. The behaviors couples engage in to maintain their relationships can impact levels of relationship satisfaction. Research suggests that individuals use positive and negative behaviors in efforts to maintain the relationship. Work by Stafford, Dainton, and Hass (2000) identified the following positive role maintenance behaviors: positivity, openness, assurances, social networks, task sharing,

advice, and conflict management. Negative behaviors, as identified by Dainton and Gross (2008), include: jealousy induction, avoidance, spying, infidelity, destructive conflict, and tolerance of partner's controlling behavior. While negative role maintenance behaviors predict the dissolution of relationships, positive role maintenance behaviors predict the continuity of stable and healthy relationships (Stafford et al., 2000). Understanding how couples engage in relationship maintenance behaviors can help to identify relationship satisfaction, quality, commitment (Stafford et al., 2000). Ideally, positive relationship maintenance behaviors are demonstrated in circumstances during the transition to parenthood. For example, in order to maintain the partner relationship, parents must engage in openness and task sharing. This would be particularly relevant for couples who breastfeed, since it is a task that requires mothers to be physically and emotionally open, especially at the outset of breastfeeding, and task sharing would benefit the family so that responsibilities are distributed effectively (e.g., while a mother breastfeeds, her partner can bring her water or complete household tasks).

Attachment Theory

A third construct related to close relationships that is strongly linked to relationship satisfaction is attachment orientation (e.g., Kachadourian et al., 2004). When attachment theory was developed, it was first studied within the context of a mother-child dyad by John Bowlby (1969) who investigated the emotional attachments of infants to their primary caregivers. Bowlby observed that when separated from their caregivers, infants demonstrate different levels of emotional distress. These observations led to the formation of attachment theory which posits that some infants display protest behaviors while others display detachment behaviors. Ainsworth (1979) expanded on attachment

theory in her work with observing infants and measuring their responses to primary caregivers. Findings from this study resulted in the designation of three styles of attachment: secure, anxious/ambivalent, and avoidant. The anxious/ambivalent and avoidant categories were similar to Bowlby's (1969) protest and detachment styles, respectively.

Hazan and Shaver (1987) further elaborated on attachment theory in an attempt to explain romantic relationships. They proposed that attachment determines how adults experience love, loneliness, and grief and how these processes progress over time. They applied Ainsworth's (1979) three-category system to the study of romantic love and suggested that attachment explains how strong bonds develop, as well how the three styles can result in various relationship behaviors. Hazan and Shaver's (1987) studies supported their hypothesis that Ainsworth's (1979) three categories of infant-caregiver attachment styles were applicable to adult romantic relationships and in similar proportions.

Research on attachment has been extended to investigate how attachment orientation influences breastfeeding. Scharfe (2012) investigated maternal attachment representations and breastfeeding initiation difficulties. Using a prospective longitudinal design, researchers measured attachment style using Bartholemew and Horowitz's (1991) 4 dimension attachment model, mood, and breastfeeding with 460 participants. Data was collected at five points: during the second half of the pregnancy, and four times within 6 months of birth. Findings demonstrated that women with attachment approach orientations had better breastfeeding initiation and duration rates and were also more

likely to persevere breastfeeding throughout initial difficulties with establishing breastfeeding (Scharfe, 2012).

This study is one of the first to examine how couples' relationship processes (in this case, attachment style) may impact establishment and continuity of breastfeeding. This research could likely be extended to include other relationship processes. In relation to breastfeeding, given that an approach attachment orientation is related to specific behaviors, furthering Scharfe's (2012) work and identifying what these behaviors are and how they are optimally carried out could serve to benefit couples who choose to breastfeed.

Limitations of Relationship Satisfaction Research

As previously noted, a general criticism of the relationship satisfaction research is that many studies use measurements that lack external validity (Mitnick et al., 2009). The typical method of assessing relationship satisfaction is with an adjustment scale such as the Dyadic Adjustment Scale (DAS; Spanier, 1976). However, despite its strong psychometric properties, the DAS provides little information about the actual behaviors that may contribute to relationship satisfaction. Scales such as the DAS do not specifically address issues that couples go through while experiencing periods of change. As such, the measurements offer limited transferability to relevant interventions for couples. A meta-analysis by Bradbury, Fincham, and Beach (2000) calls for relationship satisfaction researchers to conduct longitudinal studies so that relationship functioning can be assessed at various points over time. This would uncover factors that impact changes in satisfaction levels throughout significant periods, such as the transition to parenthood. They also suggests comparing competing theories to one another, rather than

looking to confirm existing theory. Lastly, another limitation in couples and parenting research is the heteronormative bias which overlooks families that are led by same-sex parents and other family compositions.

Breastfeeding and Relationship Factors

Despite the vast literature on romantic relationship and transition to parenthood theories, minimal research has examined the interaction between relationship constructs and breastfeeding. However, as noted, formal breastfeeding education and support programs have recently incorporated inclusion of the partner in their curricula. As demonstrated in the public health literature (e.g., Mitchell-Box, Braun, Hurwitz, & Hayes, 2013), partner participation in processes related to breastfeeding increases breastfeeding rates. Therefore, additional interdisciplinary work that aims to enhance knowledge of the mechanisms of *how* partner involvement is effective is important.

In addition, though researchers have examined the efficacy of breastfeeding support programs and how couples' perceptions of breastfeeding impacts breastfeeding rates (e.g., Susin & Giugliani, 2008), little work has assessed the impact of breastfeeding on new parents. Specifically, though breastfeeding requires considerable time and emotional and physical effort, little is known about how breastfeeding affects the partner relationship. Given that relationship satisfaction influences important couple and family issues such as relationship duration and stability, and child wellbeing (Lawrence et al., 2010), it is important to know how breastfeeding impacts relationship satisfaction.

The few studies that have looked at relationship aspects and breastfeeding have yielded limited applicable results, however they offer a starting point for future research. For example, Gibson-Davis and Brooks-Gunn (2007) investigated links between

relationship status, relationship quality, and breastfeeding initiation. They also looked at paternal emotional support, importance of father's caregiving, and father involvement. Researchers categorized 3567 female participants into four groups: married, romantically involved and cohabiting, romantically involved and not cohabiting, and not romantically involved and not cohabiting. Findings showed that married couples were most likely to initiate breastfeeding, followed by cohabiting couples. Of the few relationship factors examined, only paternal emotional support was statistically significant. Interestingly and surprising to researchers, paternal emotional support was negatively related to breastfeeding initiation for African-American women. The researchers hypothesized this may be due to the egalitarian household labor values of African-Americans, such that women who perceived their partners to be emotionally supportive felt less responsibility to breastfeed (Gibson-Davis & Brooks-Gunn, 2007). A major limitation of this study is the lack of inclusion and examination of other factors that contribute to relationship quality; as such, other important influences on breastfeeding may have been missed.

A Brazilian study by Falceto, Giugliani, and Fernandes (2003) specifically investigated whether the quality of heterosexual couples' relationships is related to breastfeeding rates. Families with infants 4 months or younger were recruited from hospital records in a low to middle class area within a major city. The researchers obtained interview and assessment data from 51 cohabitating couples who had ceased breastfeeding and 102 cohabitating couples who were currently breastfeeding. Researchers hypothesized that relationship quality would be positively related to breastfeeding duration.

Data was collected at 4 months postpartum and involved a visit in families' homes with two therapists and a videographer. The therapists conducted a 2 hour semi-structured interview and also recorded observational and behavioral data of family members. The interview portion consisted of four parts: an interview with all family members that lived in the household, an interview with the couple alone, and an interview with each partner individually. Researchers assessed relationship and parental function, satisfaction with the quality of care each partner provided the infants, and mothers' opinions of paternal breastfeeding support. Observational data also noted interviewers' perceptions of paternal breastfeeding support and paternal involvement in infant care through observation of family member interactions (Falceto et al., 2003).

Findings did not support the researchers' hypotheses that relationship quality is related to breastfeeding duration and termination. Researchers suggested this may be due to strong mother-infant bonds that compensate for a difficult partner relationship. In addition, they theorized that their sample had high accessibility to friends, neighbors, and public health resources, and such additional support could facilitate breastfeeding continuity despite unsatisfactory partner relationships. Not surprisingly, couples in which each member rated their relationship as "good" were more likely to be rated by interviewers as having more paternal support for breastfeeding and infant care involvement. However, overall, there were no differences found on any of the measured variables between currently breastfeeding couples and previously breastfeeding couples (Falceto et al., 2003).

Though this study aimed to determine relationships among breastfeeding duration and relationship quality constructs, results lacked statistical significance. Researchers

noted several possible reasons for this including small sample size, limited range of Likert scale ratings, lack of specificity of behaviors, timing issues, and uncertainty about the causal direction of relationship satisfaction and paternal involvement. The scales utilized may have provided too little information as they consisted of 3 to 4 point Likert scales which may have contributed to a central tendency effect. Further, these low-range scales did not operationalize specific aspects of support, breastfeeding, and relationship quality. Lastly, in a culture in which breastfeeding is the norm, the time of data collection, 4 months postpartum, may be when breastfeeding is well-established. Thus, relationship factors may have little bearing on breastfeeding at this time. Lastly, the researchers also note that the study did not allow for determining whether good relationships cause increased paternal involvement or vice versa (Falceto et al., 2003).

A notable strength of this study was the inclusion of various family members and incorporation of observations and assessments by therapists who are presumably skillful in assessing interpersonal wellbeing. Given that in many cultures extended family have significant involvement in the transition to parenthood, it is important that studies in the field consider, incorporate, and examine such pervasive cultural values.

With regard to the generalizability of these results, it is important to note that this study was done in a region in which breastfeeding initiation rates are much higher than they are in the United States (96% of women in Brazil versus 75% in the United States; USDHHS, 2011). In addition, the median duration of breastfeeding is much higher in Brazil (10 months, versus the United States where only 22% of mothers breastfeed until 6 months; USDHHS, 2011). In this particular study, the authors defined early weaning as 4 months post-partum and noted that 70% of Brazilian mothers breastfeed beyond this

timeframe. Therefore, it is uncertain if the results are applicable to couples within the United States, however, the examined psychosocial constructs are applicable in American culture.

Research conducted by Papp (2012) with 986 heterosexual couples in the United States investigated the influence of breastfeeding on intimate relationship quality. She examined longitudinal data from the National Institute of Child Health and Human Development. Participants were categorized into three groups: never breastfed (26.8%), initiated and terminated breastfeeding before 4 months (36.3%), and breastfed beyond 5 months (36.9%). Couples' emotional closeness and support within was assessed with the Personal Assessment of Intimacy in Relationships (Schaefer & Olson, 1981), a 6-item emotional intimacy scale. This was administered to parents when their children were 1 month, 6 months, 4 and a half years, in grades 1, 3, 5, and 6, and at 15 years old. Analyses using multivariate hierarchical linear modeling revealed that breastfeeding for any duration of time predicted increases in mothers' perceptions of relationship quality levels over time. No association was found between breastfeeding and fathers' perceptions of relationship quality. There were also no significant differences between the shorter versus longer breastfeeding duration groups. This suggests that any length of breastfeeding may be beneficial to maternal perceptions of relationship quality.

This study provided some insight into the relationship between breastfeeding and relationship quality. A primary strength of this study was the frequent assessment of relationship quality over 15 years. In addition, the authors were able to rule out the possibility that mothers who are already satisfied in their relationships are more likely to breastfeed: there were no differences found in relationship quality scores assessed at 1

month between mothers who had initiated breastfeeding and mothers who had not. Implications of these findings lend support to the notion that improved intimate relationship quality may be a psychosocial benefit experienced by breastfeeding mothers. Papp (2012) recommends that future research in this area investigate the partner processes involved in facilitating breastfeeding and the overall impact on romantic relationship functioning. She notes that breastfeeding impacts major aspects of close relationships such as relational communication and sexual intimacy. Papp also suggests that researchers seek to explain the association between breastfeeding and relationship quality by examining attitudes, confidence, and feeding intentions. The current study aims to investigate these areas of relationship functioning identified by Papp (2012). Use of CGT methodology, with its emphasis on addressing process and action, suits this endeavor.

Limitations of breastfeeding and romantic relationship research. The previous three studies noted indicate that there may be a link between breastfeeding and relationship satisfaction. However, they offer minimal insight into the specific factors that impact satisfaction, as well as the factors that impact breastfeeding initiation and duration. In addition, the breastfeeding literature largely focuses on the initiation phase (e.g., Vari, Camburn & Henly, 2000; Barry & Tighe, 2013) which, due to temporal limitations, may not allow for consideration of the various aspects of the lengthier transition to parenthood period of time. It may be that the day to day interactions throughout the postpartum period, such as relationship maintenance behaviors, as well as the trajectory of the breastfeeding-related activities, contribute to partner relationship

satisfaction. However, no such research investigating these processes has been conducted to date.

Breastfeeding and Sexual Functioning and Intimacy

Though there is a dearth of research on how breastfeeding impacts couples' relationship functioning and satisfaction, the impact of breastfeeding on couples' sexual relationship has been addressed, particularly in the medical literature. LaMarre and colleagues (2003) conducted a review of research on postpartum maternal sexual functioning and breastfeeding. The authors defined sexual functioning as "the combination of sexual desire, frequency, enjoyment, and orgasm" (p. 153). In general, findings reveal that compared to non-breastfeeding women, women who breastfeed are more likely to experience decreases in sexual functioning, particularly related to sexual desire. The authors attributed this to both psychosocial and hormonal factors. They also suggest that these changes in sexual functioning are likely to cause distress due to implications on overall relationship functioning. Further, they note that these difficulties can affect general communication and are likely to exacerbate if left unattended. However, despite these findings, no studies to date have investigated the links between breastfeeding, sexual functioning, and relationship functioning.

Changes in sexual functioning is yet another aspect of the transition to parenthood and breastfeeding that women and couples must navigate. However, such issues may not be addressed or may be minimized due to various reasons including stigma, and other pressing priorities. LaMarre and colleagues (2003) explore several areas regarding impact of breastfeeding on sexual functioning. Hormonal changes that can affect sexual functioning of breastfeeding women include lower levels of estrogen which can decrease

vaginal lubrication, increased genital vasocongestion (increased blood flow), and narrowing of the vaginal opening. These physiological changes can contribute to decreased sexual arousal and uncomfortable or painful sexual intercourse. Another psychological factor related to breastfeeding that may influence sexual functioning is mood, though the research has been mixed in this area. Increased levels of oxytocin, which is associated with breastfeeding, has been found to increase positive mood. However, research also indicates that postpartum depression, which afflicts 10-15% of new mothers and is associated with decreased sexual desire and activity, may be related to breastfeeding, though findings are inconsistent. LaMarre and colleagues (2003) note that the research does consistent demonstrate that sexual dysfunction of breastfeeding women appears to be positively related to breastfeeding duration. They also suggest that fatigue due to lack of sleep can impact sexual desire. However, recent research demonstrates that breastfeeding women obtain more sleep than non-breastfeeding women (e.g., Kendall-Tackett, Cong, & Hale, 2011). Lastly, the authors note that sexual functioning problems can be complicated by lack of patient disclosure to medical professionals. An unfortunate outcome of this is that potential treatment or education is not addressed and without intervention or support, problems may unnecessarily continue and potentially worsen.

Overall, the studies reviewed largely posit that the factors related to decreased sexual desire and activity in breastfeeding couples are either related to physical and emotional discomfort or disinterest by the woman (LaMarre et al., 2003). Though some of the research very briefly discussed these challenges, no studies address the communication processes that underlie sexual interactions. For example, examination of

how non-sexual intimacy and other forms of affection within breastfeeding couples could shed light on behaviors that promote relationship satisfaction. As it stands now, there are gaps between the research on sexual functioning, relationship dynamics, and breastfeeding.

The importance of investigating sexual functioning and its implications on new parents cannot be overstated. Overlooking this area can prevent couples and health professionals from becoming aware of underlying processes that affect relationship. For example, having knowledge of the noted hormonal changes could facilitate couples' communication about sexual issues and alleviate perceptions of responsibility or blame. Research indicates that increased general communication, as well as disclosure of sexual preferences and aversions, is associated with increased sexual satisfaction (MacNeil & Byers, 1997). The omission of discussion of sexual issues of new parents may be related to the stigma associated with perinatal women's sexuality. LaMarre and colleagues (2003) believe this stigma has contributed to a lack of research in this area.

In addition, very little research has investigated women's perceptions of partners' sexual desire and their experiences of the physical and psychological changes related to birth and breastfeeding. Even less research has examined these matters from the non-breastfeeding partner's perspective. For example, no research has investigated whether or not relationship satisfaction is related to frequency or type of sexual activity in breastfeeding couples. As noted, the studies that do examine breastfeeding and sexuality focus on sexual dysfunction and breastfeeding outcomes, and not relationship functioning, satisfaction, or quality.

Therefore, a more in depth understanding of the specific factors involved in how breastfeeding impacts the partner relationship and how the partner relationship impacts breastfeeding is needed. As public health policies and programs target improvement of breastfeeding rates, it is increasingly necessary to understand how breastfeeding impacts the partner relationship, as this has implications on family wellbeing (Schulz, Cowan, & Cowan, 2006). The current study looks to bridge the gap between multidisciplinary areas of research that share the goals of uncovering factors related to breastfeeding and relationship quality. Such information may serve to increase breastfeeding rates, and to improve relationship satisfaction and family functioning.

In addition, this research is particularly important because studies suggest that new parents are especially open to interventions and education (Halford, Markman, Kline, & Stanley, 2003). In addition, according to Mitnick et al.'s (2009) meta-analysis of the transition to parenthood and relationship satisfaction research, attending prenatal classes appears to mitigate decreases in relationship satisfaction. As such, the prenatal and early postpartum period may be an particularly efficacious time to target parents with programming that can support relationship functioning and satisfaction. This may then serve to buffer the imminent decline of relationship satisfaction couples experience (Mitnick et al., 2009). Cowan and Cowan (1995) recommend that interventions address relationship aspects such as shared realistic expectations, mutual support, and healthy communication.

To this point, the literature review has addressed the breastfeeding, transition to parenthood, and relationship satisfaction research. There is no question that there has been a great deal of attention paid to each of these areas. However, there is a lack of

research on the interaction between breastfeeding, the transition to parenthood, and relationship satisfaction. No studies to date have identified how breastfeeding impacts relationship satisfaction and vice versa from the perspective of breastfeeding mothers. Due to the importance of these processes on couple and family functioning and well-being, the current study aims to potentially fill this void using a Constructivist Grounded Theory approach. The next section will outline the development and tenets of CGT, discuss a rationale for the use of CGT in the current study.

Grounded Theory

Grounded Theory (GT) is qualitative research method. Qualitative methodology is particularly beneficial to investigate areas of research such as the current study because it allows for an in-depth examination of issues and uses participants' actual experiences, perceptions, and words. Though quantitative methods can be effective for some types of research, a significant limitation is that it can impose pre-defined constructs on issues and can thus overlook important constructs that are not directly addressed by the research methods. Using a qualitative approach can uncover and demonstrate the rich details of important concrete and abstract experiences, without making assumptions about researchers solely determining what the focus should be, and what should be measured.

GT is a particularly appropriate qualitative approach for exploring the interaction between breastfeeding and romantic relationships for the following reasons. According to Charmaz (2006), GT methods “consist of systematic yet flexible guidelines for collecting and analyzing qualitative data to construct theories ‘grounded’ in the data themselves” (p. 2). In GT, data is collected and analyzed, concepts are discerned and constructed, and the foundation of a theory is formed. Though most qualitative methods offer flexible data

collection and analysis methods, an advantage of GT is that it also outlines specific and structured procedures related to data management (Charmaz, 2006). Fassinger (2005) notes that GT is appropriate for counseling psychology research because of its “focus on generating experience-near theory regarding important social contexts, and its applicability to a wide range of issues of interest” (p. 165) to the field. Given the lack of research and theory that addresses the interaction of breastfeeding and relationships, GT is particularly applicable to this study. The development of a grounded theory related to the current study may have implications on potential interventions that could enhance the satisfaction and functioning of couples and the wellbeing of families.

GT was developed by sociologists Barney Glaser and Anselm Strauss during their research on the experiences of terminal hospital patients and hospital staff (1965). As they investigated a social issue that had minimal prior literature, they established standard procedures which came to be known as GT (Glaser and Strauss, 1967 in Charmaz, 2006, p. 4). They developed the method to be applicable across disciplines, particularly in the social sciences. Glaser and Strauss believed in creating theory based directly on research data findings, and they were critical of the practice of inferring hypotheses from existing theories (Glaser and Strauss, 1967 in Charmaz, 2006, p. 4).

Glaser and Strauss’ work in the 1960s and 1970s emerged at a time in which quantitative culture within sociology and the social sciences was at its peak. The dominant paradigm of positivism placed emphasis on the scientific method. Researchers strived for objectivity, generalizability, replication, and often aimed to falsify hypotheses and theories that were different than one’s own. In the social sciences, positivist researchers pursued development of causal explanations and predictions of an objective

world. The belief that facts can be separated from values resulted in the assumption that knowledge of the world can be accumulated in an unbiased and passive manner. At this time, the use of qualitative research was limited to preliminary methods of collecting information through interviews or observation to construct surveys (Charmaz, 2006). Quantitative research during the 1960s aimed to refine theory, but very seldom created new theory (Charmaz, 2006).

Glaser and Strauss' (1967) development of GT incorporated positivist ideals while aiming to enhance the richness of research outcomes. Prior to their approach, qualitative research had been primarily implemented by researchers who were immersed in field settings for extended periods of time. However, there was little guidance on how to analyze the extensive data they acquired. Glaser and Strauss (1967) argued that qualitative analysis could be systematic, logical, and could produce theory, particularly that of abstract social processes. They suggested methodology procedures such as: concurrently collecting and analyzing data, using the data to create theory rather than imposing theory, constant comparison of data, memo-writing, sampling for theory construction and not representativeness, and completing the literature review following data analysis. (Many of these concepts will be expanded on in later sections as they apply to the current study.) The primary goal of these recommendations was to encourage qualitative researchers to standardize the research process (Charmaz, 2006). Thus, qualitative research moved beyond merely describing phenomena and now contributed to explaining it through development of novel theories. Glaser and Strauss' (1967) definition of a grounded theory is a theory that fits the data, is useful, conceptually dense, durable over time, modifiable, and explains phenomena (Charmaz, 2006).

The development of GT merged Glaser's training and preferences for empiricism, rigorous coding, and structure with Strauss' values of human agency, process, and subjective and social meanings. They proposed that a primary function of a grounded theory is to identify and develop abstract constructs and to determine associations among them in order to understand problems. Indeed, GT has been applied within various disciplines as a respected research method, particularly in the fields of sociology and nursing (Charmaz, 2006).

Following their initial collaborations, Glaser and Strauss (1967) began to diverge on what they each considered to be integral to GT research. Glaser's approach is often labeled as "classic GT" and he continues to distinguish GT as a "method of discovery" wherein categories arise from the data (Charmaz, 2006). In contrast, Strauss began to emphasize the technical procedures of data analysis (Strauss & Corbin, 1990, 1998). Glaser argues that this method forces data and analysis into predetermined classifications and contradicts the fundamental philosophy of GT (Glaser, 1992, in Charmaz, 2006). Nonetheless, though GT had initially been developed as a response to positivist approaches, the culmination of the work of GT researchers through the 1990s solidified the method as a rigorous and useful approach in social science research. Interestingly, GT has been simultaneously criticized and embraced for its positivistic assumptions. This eventually prompted qualitative researchers to create GT methods that are more constructivist in nature.

The current study utilized a constructivist approach to GT methodology as developed by Kathy Charmaz (2006, 2014). Indeed, Glaser and Strauss (1967) had initially encouraged researchers to use GT approaches to fit their research and Heath and

Cowley (2004) also recommend this strategy in their review of GT. Charmaz (2014) provides guidelines of how to do this in her book, *Constructing Grounded Theory, 2nd Edition*. Her approach revisits the original GT tenet of developing abstract explanatory understandings of the data while incorporating constructivist theory (Charmaz, 2006, 2014). In contrast to Glaser and Strauss' (1967) initial views, Charmaz (2006, 2014) argues that the researcher is a part of the world and the data, and is not disconnected or absent from it. Therefore, CGT researchers interpret data through the lens of their past and current experiences, and do not present an exact picture of the data, but rather their constructions of reality.

Charmaz (2006, 2014) states that rich data provides the basis of a strong analysis. Rich data is “detailed, focused, and full” and uncovers “participants’ views, feelings, intentions, and actions as well as the contexts and structures of their lives” (p. 14). Through CGT research methods, the goal is to view the world from the eyes of the participant as much as possible. Charmaz (2006, 2014) states the importance of being flexible and following the themes that emerge in the data. She likens data collection and analysis to a wide lens view that gradually zooms in to see the detail up close. Use of a “keen eye, open mind, discerning ear, and steady hand can bring you close to what you study and are more important than developing methodological tools” (Charmaz & Mitchell, 1996 in Charmaz, 2006, p. 15). Charmaz’s approach is advocated by Corbin and Strauss (2008) who note the strength of using a postconstructivist lens to strengthen interpretations. With regards to the GT controversy of what constitutes forcing data, Charmaz (2006) acknowledges that one researcher’s forcing might be another’s adaptive method of data collection. For example, Glaser (1998) advises against the use of

interview guides, following diagrams, and rules for memo-writing, whereas Charmaz (2006, 2014) argues that having an interview guide enhances the probability of asking open-ended questions and avoiding leading questions. The Method chapter will further describe the methodological procedures of Charmaz's CGT as used in the current study. In the following section, the purpose of this study is presented.

Purpose

As noted in earlier in the literature review, research indicates that the transition to parenthood is a time of many changes across almost every aspect of life for most parents. The implications of such changes and how they impact parents is a frequently studied topic (e.g., Gottman, et al., 2010; Howard & Brooks-Gunn, 2009; Shapiro et al., 2000). An area of particular focus in the literature has been on how parenthood impacts relationship satisfaction and functioning. Research has consistently indicated that relationship satisfaction gradually declines following the birth of a child, however it also indicates that it gradually declines in all types of relationships, regardless of child or marital status (Mitnick et al., 2009). What is less clear is what factors contribute to or buffer against these declines in relationship satisfaction.

Further, an aspect of new parenthood that has been minimally studied in the context of the romantic relationship is breastfeeding. The benefits of breastfeeding as a method of infant feeding are well-known across disciplines (Ho, 2013). However, despite this widespread notion, breastfeeding rates in the United States are among the lowest of developed countries (STC, 2012). The volume of research that has aimed to explain this issue is a testament to the importance and complexity of breastfeeding. However, though much research has revealed the barriers and facilitators of breastfeeding, little

examination at the level of the partner relationship has been done. For partnered women who are breastfeeding, there is a need to explore the impact of the relationship dynamic on the experience and duration of breastfeeding. In addition, there is also a need to investigate the effects of breastfeeding on the partnered relationship, including factors such as relationship processes, satisfaction, and functioning, in order to increase understanding of how breastfeeding impacts couples.

Knowledge about how breastfeeding impacts the romantic relationship and vice versa can inform interventions such as perinatal support classes, breastfeeding education and support groups, workplace policies, and development of new breastfeeding initiatives. Further, breastfeeding is a topic that receives minimal attention in mainstream media, unless there is sensationalism or controversy associated with it. Therefore, the general public sees a skewed account of breastfeeding. In addition, cultural norms related to sexualization of breasts and objectification of the female body often prevent the topic of breastfeeding to be discussed as the everyday and widespread issue it is (Convery & Spatz, 2009). As a result of these circumstances, breastfeeding misconceptions are rampant. Therefore, research that can enhance practical and scientific knowledge in this area can serve to prepare expectant parents to anticipate how breastfeeding may impact their relationship, and what they can do to support each other and the relationship.

Because there is a lack of specific and quantitatively measureable constructs in this area, qualitative research methodology was selected for the current study. When used appropriately, qualitative methods allow researchers to gather rich data on phenomena and complex experiences of populations. Use of qualitative research is particularly important in areas in which limited study has occurred and in populations that are

marginalized and underrepresented in research. While quantitative research requires constructs to be explicitly defined in advance of data collection, a qualitative approach such as CGT allows for the participant to define the data. Since research in the area of breastfeeding and its interaction with relationship satisfaction is limited, utilization of qualitative methodology will allow for the ability to collect data without imposing the dominant culture's theories or hypotheses. Further, CGT enables the participants' unique experiences to be elaborated on through the development of a theory grounded in their lived experiences. Development of a theory is beneficial for both enhancing an understanding of an important and often misunderstood issue, as well as to create a potential springboard for future studies to consider and expand upon (Charmaz, 2006, 2014).

Rationale for participant inclusion criteria will now be addressed. Multiparous women were excluded from the study so that participants could best recall the experiences specific to their only and initial experience of breastfeeding and the transition to parenthood. In addition, research indicates that the experiences of primiparous breastfeeding women are different than that of multiparous women. Research indicates that primiparous women are more likely to have early breastfeeding problems, more likely to be supplemental feeding upon discharge, and less likely to be breastfeeding at 6 and 12 months postpartum (Hackman, Schaefer, Beiler, Rose, & Paul, 2015). The 3 to 8 month postpartum timeframe was chosen due in order for breastfeeding to be well-established and the main source of nutrition for infants, inclusive of those who have been introduced solid foods as they are not yet a primary source of nutrition at this time. This timeframe also allows the participants to have likely recovered from the birth, and also

allowed for variation of mothers who returned to work outside the home, or had made the decision not to. An infant feeding study by Launer et al. (1992) demonstrates that mothers can provide accurate retrospective recall about postpartum events for up to 18 months.

Lastly, inclusion criteria required women to be in a current and committed relationship because the partner involvement and the romantic relationship were primary areas of focus for the study. However, marital status or gender was not specified as inclusion criteria because research that has compared same-sex couples and mixed-sex couples have not found differences in levels of relationship satisfaction (Antonelli, Dèttore, Lasagni, Snyder, & Balderrama-Durbin, 2014; Kurdek, 2005; Means-Christensen, Snyder, & Negy, 2003).

Thus, the purpose of the current study is to explore the interaction between breastfeeding and committed romantic relationship satisfaction of partnered, co-habiting primiparous mothers at 3 to 8 months postpartum and currently breastfeeding. The essential question of this study is, from the perspective of the mother, how does breastfeeding interact with partner relationship satisfaction and functioning? To explore these areas, CGT methodology was employed as a way to capture the experiences of participants by using their words to inform the development of a theory. Participants were asked about their breastfeeding and transition to parenthood experiences, relationship satisfaction, functioning, and closeness, and perceptions of partner involvement and support.

CHAPTER III

METHOD

This study explored the experiences of mothers at the 3 to 8 month postpartum mark who were currently breastfeeding and in a romantic relationship. In-depth, open-ended interviews, termed “intensive interviews” by Charmaz (2006, 2014) asked participants about their breastfeeding and transition to parenthood experiences, romantic relationship satisfaction, functioning and closeness, and perceptions of partner involvement and support. Particular attention was paid to how the relationship has changed over the course of the prenatal and postpartum period, breastfeeding attitudes of both partners, perceptions of how partners facilitate and hinder breastfeeding, and how breastfeeding has impacted aspects of the relationship. This chapter will describe the methods of the study including procedures for participant recruitment, interviewing, and coding and analyzing the data.

Participants

Individuals eligible for study inclusion were primiparous mothers at the 3 to 8 month postpartum mark, currently breastfeeding, and in a romantic relationship with cohabiting partner. Further detail for each of this inclusion criteria is as follows. “Primiparous” denotes mothers who have given birth to one child and mothers were required to be breastfeeding this child to be eligible for the study. Participants were required to have given birth to the child within 3 to 8 months prior to the date of the

interview. “Currently breastfeeding” denotes that the infants’ primary source of nutrition is the mother’s breast milk which may be provided via the breast or other means such as a bottle or cup. Inclusion in the study also required that the infant have been exclusively breastfeeding. In other words, the infant must have been primarily fed breast milk, however, temporary supplemental feeding (e.g., formula), and recent introduction of solid foods is were also appropriate for inclusion. Lastly, participants had to be cohabitating with an individual they are in a committed, romantic relationship with and who is considered to be a parent of the infant.

Further participant inclusion criteria and procedures are as follows. Participants resided in the United States or Canada and were at least 18 years of age. Participants engaged in a 1.5 to 2 hour phone interview with the principal investigator during March through May 2015. Participants consented to be contacted by the principal investigator following this interview in order to confirm the transcript and to clarify data as needed, per the constant comparative analysis as recommended by CGT (Charmaz, 2006, 2014). Participants were informed from the outset that they may withdraw from the study at any time without penalty. Nine women initially expressed interest in the study. At the time of the interview, the third scheduled interviewee had recently implemented formula feeding which she estimated to be 70% of her infant’s nutritional intake. Therefore, she was deemed ineligible for the study. The remaining eight participants completed the study.

Participants ranged from age 19-33 years old with an average age of 27.5 years. Infants’ ages ranged from 3 to 8 months old with an average age of 5 months. Seven participants were married, while one was unmarried and in a committed relationship. Relationship duration ranged from 3 years and 4 months to 12 years and 1 month with an

average duration of 8.65 years. Seven participants identified as White while one identified as African-American and White. Of the eight participants, five were currently working outside of the home part time and each had plans to return to fulltime work within a few months. The other three planned to return to work outside the home when their infant turned around one year old. Five of the participants' highest degree of education was a Bachelor's degree and the remaining three held the following degree types: high school, Master's, and Doctorate. Seven participants lived in the United States (four in the Midwest, two in the South, and one in the West) while one lived in Canada (British Columbia).

The number of participants included in the study depended on when the data met saturation. Saturation, as defined by Charmaz (2006, 2014), is when concepts and themes are repeated in interviews such that additional interviews do not enrich the data. In other words, when saturation is met, no new information is uncovered through interviews. Studies that have utilized GT methodology typically include eight (e.g., Corbet-Owen, 2003) to fourteen participants (e.g., Lauckner, Paterson, & Krupa, 2012) before saturation is met. In the current study, following the eighth interview, no new themes were uncovered and recruitment was halted.

Measures

Participants completed a brief electronic questionnaire which screened for study inclusion criteria, as well as asked participants about demographic information for self and partner. The questionnaire asked them to identify their name, email address, phone number, ages of self, partner, and infant, relationship status and duration, household income, religiosity, brief mental health history, as well as to identify race, ethnicity,

sexual orientation, and employment status of self and partner (see Table 1). Participants were also asked to provide a mailing address in order to send the compensation checks to them.

Table 1. Participant Demographics.

Participant	Age	Age of infant	Relationship status	Relationship duration	Race	Currently work outside home	Education
Ann	28	8m	Married	6 years 11 m	White	Yes	Master's
Francis	33	8m	Married	12 years 1 m	White	No	Bachelor's
Grace	19	3m	Committed	3 years 4 m	White	Yes	High school
Idina	26	3.5m	Married	7 years	White	Yes	Bachelor's
Lee	25	3m	Married	7 years 10 m	White	Yes	Bachelor's
Marie	30	6.5m	Married	11 years	Bi-racial	No	Bachelor's
Noelle	29	5m	Married	10 years	White	No	Bachelor's
Teresa	30	4m	Married	11 years	White	Yes	Doctorate

Research Team

The research team consisted of an interviewer and two readers. The interviewer is the principal investigator (PI) and is a Counseling Psychology doctoral student. The interviewer conducted the interviews, transcribed the interviews, and coded and analyzed the data. Per Fassinger (2005), the reader roles are of an “inquiry auditor” and “peer debriefer”. The inquiry auditor is an associate professor and is the PI’s advisor and committee chair. The peer debriefer is a former classmate and holds a Master’s degree of Arts in Counseling, as well as a Master’s degree in Public Health. The readers’ tasks involved providing feedback on interview questions and protocols, consulting about CGT methods, and coding and analyzing data. Dialogue about power differential and biases was addressed throughout the research process and each team member was invited to share their opinions and reactions. Interaction between the PI and inquiry auditor was primarily in person and by phone every one to two weeks during data collection and

analysis phases, while interaction between the PI and peer debriefer was primarily by email due to geographic distance.

In GT, it is typical for researchers to reflect on and present their experiences and biases related to the research at hand. The PI of the current study is a 33 year old, white, married, cisgendered, heterosexual, agnostic female. She has a 3 year old daughter and extensive experience in breastfeeding, both in personal and professional realms. She obtained her Certified Lactation Counselor certification in 2014 and is currently completing the process of recertification. She grew up in Vancouver, Canada and she is in a Counseling Psychology doctoral program at a Midwestern university. She currently lives on the west coast in the United States.

The inquiry auditor is an associate professor in the Counseling Psychology department at a Midwestern university. She has thorough research experience in the areas of relationships, communication, counseling, and qualitative methodology. She identifies as a middle aged, white, same-sex partnered stepmother of two.

The peer debriefer holds a Master's degree of Arts in Counseling, and a Master's degree in Public Health. She has experience working with mothers in counseling and advocacy roles, as well as with health policy. She is a single mother of a young teenager and identifies as white, queer, atheist, and cisgendered. She notes that as a teen mother, she was not provided the knowledge, resources, or support to breastfeed her child. She grew up in the Midwest and currently lives on the east coast in the United States.

Procedure

This section expands on the procedures that were addressed in the literature review. Recruitment advertisements were posted to social network sites including

Facebook and pregnancy and parenting information websites and forums and through word of mouth via colleagues of the PI. Participants who were involved in the study learned of the study through direct referral from colleagues and shared Facebook posts. They received \$30 to compensate for their time. Study advertisements posted online and sent to participants who heard about the study through word-of-mouth included a description of the study and the principal investigator's contact information. When potential participants identified interest in the study, the PI emailed the informed consent form to them. In addition, information about possible interview times, an overview of participant roles, and reiteration of inclusion criteria, such as confirmation that their infant's age was between 3 and 8 months was communicated. Following return of an electronically signed consent form, a phone interview was scheduled. Three days prior to the interview, an email reminder was sent, as well as the demographics questionnaire. All eight participants emailed back their completed questionnaires prior to the phone interview.

Phone interviews were audio recorded on digital audio recorders. Following each interview, the recording was uploaded to the PI's password protected laptop. The \$30 compensation check was then mailed to participants. Interviews were then de-identified and transcribed and stored on the same password protected laptop. Transcripts were emailed as password-protected documents for participants for review. Two participants emailed to clarify a response they had shared during the interview and this information was incorporated into their transcripts.

Data Collection

Though GT methods allow and encourage data collection of various media, the current study utilized intensive interviews. Interviewing is a longstanding method of qualitative research for various reasons. It allows for the researcher to gather in depth information, and prompts participant responses that capture interpretations of their experiences. Charmaz notes that intensive interviewing complements CGT methods as both are “open-ended yet directed, shaped yet emergent, and paced yet unrestricted” (Charmaz, 2006, p. 28). Throughout the interview, the interviewer aims to gain an understanding of the participant’s perspective. Charmaz recommends starting by assembling a few general, non-judgmental and open-ended questions and then integrating more focused questions to elicit further detail. These processes were implemented in the current study as additional interviews unearthed new areas of emphasis. Building rapport and active listening is encouraged in order to enhance the trust and openness of participants. Other recommendations for interviewers include redirecting, going back to an earlier answer, validation of participants’ experiences, asking for clarification, and discussing feelings, actions and thoughts. Expressing gratitude for participants’ effort and time is also expected.

CGT emphasizes the importance of interviewers’ awareness of their unintended influences on an interview and how this impacts participants. For example, power differentials, cultural expectations and various demographic variables may influence the openness of a participant, unknowingly or not. Particularly relevant to the current study is that women who are interviewed by women commonly volunteer to be interviewed for a variety of sensitive topics, sometimes in retaliation of oppression or silencing (Charmaz,

2006). Responses during and following the interview may be variable and may include emotions such as feeling validated, liberated, uncomfortable, pain, or overwhelmed. The topic, its meaning, the circumstances of participants' lives, as well as interviewer skills all impact how women experience their interviews (Charmaz, 2006).

Pilot interviews. Pilot interviews were conducted and recorded with two of the PI's close friends who were new mothers and had enthusiastically agreed to provide feedback regarding study procedures and interview content. The first volunteer completely met study inclusion criteria and has experience in the counseling field. The second volunteer had breastfed her now toddler son for several months and is a birth doula and birth photographer. The readers reviewed parts of the audio tape or transcript and provided feedback on interview pace, enhancing minimal encouragers, and follow-up questions. The two pilot interviews also provided useful knowledge on interview logistics such as becoming more familiar with the recording equipment, assessing length of the interview, practicing vocalizing the interview questions, and identifying and revising any potentially leading questions.

Interview protocol. A semi-structured, intensive interview format which is consistent with GT methodology was implemented (Charmaz, 2006; Strauss & Corbin, 2008). Semi-structured interviews allow for consistency in general questions, as well as flexibility in order for the interviewer to address the emerging stories and themes of the participant's dialogue. Questions addressed participants' experiences with breastfeeding, the changes and challenges related to the transition to parenthood, partner involvement in breastfeeding, and how breastfeeding has impacted the relationship with their partner. Participants were also asked to briefly share about any complications in the pregnancy,

their perceptions of the birth, and any medical issues with anyone living in the home. The following questions are specific examples of questions that were addressed. Per CGT, the content of the interview evolved as data was analyzed in order to best capture the experiences being studied (Charmaz, 2006). Additional questions that are not noted specifically, but are related, were asked as needed to encourage follow-up, elaboration, and clarification of participants' experiences. The interviews covered three primary topics in a non-linear fashion: breastfeeding, the transition to parenthood, and relationship satisfaction.

Interview questions.

How has being a new parent been?

How has being a parent changed your relationship with your partner?

How do you and your partner manage your day to day family tasks?

Tell me more about how you and your partner communicate in general.

How close do you feel to your partner? Vice versa?

Tell me about how breastfeeding has been going.

How did you decide to breastfeed? What were your expectations?

How committed have you been/are you to continuing breastfeeding?

What social influences or cultural messages related to breastfeeding have you experienced?

How has breastfeeding impacted how you see your body?

Tell me about your partner's involvement in breastfeeding.

What are your partner's perceptions of breastfeeding?

How has your partner supported/not supported breastfeeding?

How has your relationship with your partner influenced your breastfeeding experiences?

How has breastfeeding affected how close you feel to your partner?

What changes have occurred in your relationship that you believe are related to breastfeeding?

As far as you know, how does your partner perceive the impact breastfeeding has on your relationship?

What could have made your experiences related to breastfeeding more positive?

What has helped/hindered breastfeeding?

Transcription

Following the initial interview, the PI transcribed the interview in its entirety per Charmaz's (2006) recommendation to utilize any data possible for data analysis.

However, in order to protect the privacy of the participants, identifying information was de-identified and each participant was assigned a pseudonym. The transcripts were emailed to the participants in password-protected electronic document form. In line with GT, participants were asked to review the interviews if they chose to do so and to respond with any additions, deletions, or clarifications. Participants were also offered compensation to schedule a follow-up interview should they wish to discuss anything further with the PI, however no participants chose to do this. All transcripts were reviewed by the readers who provided feedback about interview content, style, and recommended revisions for future interview content.

Data Analysis

As noted, data was analyzed per Charmaz's (2006) CGT recommendations. The PI reviewed the transcripts several times throughout the coding and analysis process in

order to implement the constant comparison technique. This allowed for the PI to compare existing codes with emerging codes and to ultimately determine categories and an emergent theory (Glaser, 1978). The inquiry auditor reviewed the coding procedures and monitored the development of the codes and categories. The PI recorded feedback in the form of memos (Charmaz, 2006, 2014) during and following regular meetings with the inquiry auditor in order to document the process of interviewing, coding, and analysis. The peer debriefer also noted memos as they reviewed the transcripts and shared these with the PI. Eventually, a working model based on the emerging themes was established. This model was continually revised and expanded upon as interviews and consultation among team members occurred. At the point of saturation, when no new information was gleaned from the data, a grounded theory was developed. The following sections provide additional detail regarding the coding processes within CGT, as identified by Charmaz (2006, 2014).

Initial coding. Charmaz (2006) notes that coding is “the process of defining what the data are all about” (p. 43). The first step within this is initial coding which involved comparing transcripts and noting what the general content suggests by looking closely at the words used to describe the phenomena at hand. At this stage, particular attention was paid to the actions noted by the participants. Charmaz recommends that researchers “try to remain open to seeing what you can learn while coding and where it can take you” (Charmaz, 2006, p. 48). Initial coding was done line by line, with each line of the transcript being assigned a code. Charmaz’ (2006) recommendation of noting brief codes while also preserving words related to action and process was implemented in order to emphasize core aspects of the issues under study. As Charmaz (2006) recommends,

during initial coding, the PI and inquiry auditor noticed gaps in the content of the interview questions which prompted additional follow-up questions during the interview, as well as revisions to the core interview questions for future interviews.

Focused coding. The second stage in analysis was conducting focused coding. This involved the PI developing “directed, selective and conceptual” coding (Glaser, 1978, in Charmaz, 2006) by examining and coding larger segments of the data. This was done by taking the significant and frequent initial codes and further categorizing them. In addition, the process of constant comparison of the data was implemented at this point. This allowed for similar themes within and across participants that were not initially evident to be uncovered and elaborated upon. For example, the peer debriefer provided feedback related to noticing that several participants felt shame about breastfeeding and thus tried to hide it from family and friends, despite their commitment to breastfeeding. The inquiry auditor suggested exploring and identifying the theme feeling a sense of duty toward their partners which was both implicitly and explicitly indicated.

Axial coding. Charmaz (2006) notes that axial coding is a third coding step according to Strauss and Corbin (1998; Corbin & Strauss, 2008). This procedure connects categories to subcategories, that is, it “specifies the properties and dimensions of a category” (Charmaz, 2006, p. 60) and puts them in a logical sequence. It allows for the building of layers around a core theme and brings the data back as a whole following the fragmentation processes in initial and focused coding. There are several ways in which GT researchers approach axial coding. Clarke (2005), a postconstructivist grounded theorist, recommends creating diagrams to reflect axial coding. Corbin and Strauss (2008) recommend organizing data by noting the context and cause of the phenomena,

actions and interactions related to managing the phenomena, and the resulting consequences of the actions and interactions. The current study utilizes axial coding to link the three broad topics (breastfeeding, transition to parenthood, and relationship functioning) and to anchor the subcategories and highlight core themes in a sequence that reflects participants' experiences.

Constructing theory. Charmaz (2006) presents several methods that GT researchers have used to create theory following the coding process. She states that developing a theory involves “*seeing* possibilities, *establishing* connections, and *asking* questions” and that “constructing theory is not a mechanical process” (p. 135). Charmaz (2006) is a proponent of interpretive theorizing which attempts to explain explicit processes and reveal implicit meanings and processes. Similar to her recommendations within coding procedures, Charmaz (2006) suggests paying close attention to all actions and processes and noted by participants. Further, she places emphasis on exploring the conditions, contexts, conceptual relationships, and consequences related to these actions and processes. The outcome of the current study is a model that attempts to explain the interaction between breastfeeding and the partner relationship, with the co-constructors as the participants and the researchers.

Theoretical Sampling and Saturation

Additional GT procedures were implemented in this study. Theoretical sampling allows for necessary data to be obtained in order to develop the aforementioned model and to expand upon and enhance the richness of the categories that make up the model. In the current study, general recruitment resulted in a sample that provided to a range of experiences, and no attempt was made to alter recruitment methods. When no new

information emerged in the data, the point of saturation was reached. Charmaz (2006) notes that categories are often thin and shaky after the initial development of categories. Purposive sampling allows for enhancing the robustness and explanatory power of categories. This procedure includes administering follow-up with second interviews or recruiting new participants who have likely had experiences relevant to the categories of interest. However, in the current study, purposive sampling was not required as the first eight participants provided a range responses which led to the development of robust subcategories of interest.

Safeguards

Corbin and Strauss (2008) state that researchers must be continually aware of their influence on the data and vice versa as a means of safeguarding the quality of the data. This is conducted through memo-writing, immersion in the field, and researcher self-reflection which is detailed in the next three sections.

Researcher dialogue. In line with GT, the researchers involved in the current study practiced self-reflection and processed reactions with one another in order to elicit awareness of researcher biases that could potentially undermine the data. Throughout researcher meetings and correspondence, discussion of how to balance participant autonomy, beneficence, and adherence to CGT process was ongoing. These discussions informed adjustments to the interview questions. Having a dialogue about attitudes, perspectives, and reactions toward the participant population also provided an opportunity to highlight reader biases that were not previously uncovered in the initial interview formation stage.

Memo-writing. Memo-writing is the process of recording analytic notes throughout data analysis. Charmaz (2006) states that memos identify thoughts, comparisons and connections made by researchers, and helps generate questions and directions for further pursuit. They are an informal strategy for eliciting ideas and insights. Charmaz (2006) states that “putting things down on paper makes the work concrete and manageable- and exciting” (p. 72). Though there are no specific methods for how to record memos, Charmaz recommends jotting notes quickly in order to best capture the stream of thoughts and reactions when reviewing data. She also recommends that researchers write memos “however you write and in whatever way advances your thinking” (p. 72). Researchers can then utilize the memo immediately, or put it aside for later use. These processes were used in the current study by using the “comments” function in Microsoft Word to make memos on the transcripts in relation to interview data, as well as using free association to record ideas, hypotheses, and questions onto a blank Word document. Memos were also recorded during researcher meetings, and prior to, during, and following interviews.

Immersion in the field and researcher self-reflection. Memo-writing also allows for a record of self-reflections to be tracked (Charmaz, 2006). It is hoped that these memos and self-reflections will allow for furthering self-awareness of personal biases and assumptions may otherwise not be consciously recognized, in order to minimize impact on the data. To further strengthen the acknowledgement of personal biases, this section will utilize a first person perspective. This self-reflection was initially written prior to the dissertation proposal meeting and has been since revised and updated to include recent experiences.

My experiences related to the study constructs are important to present here in order for the reader to have a sense of who I am and where I have come from given that the researcher is a tool of the research (Charmaz, 2006, 2014). As a result of my beliefs, knowledge, and experiences related to breastfeeding, I am mindful that I have strong biases about it. I have a 3 and a half year old and I attribute my interest in this area of research largely to her. Though I had little exposure to breastfeeding prior to my pregnancy, when considering how I would feed my daughter, I quickly determined that I would breastfeed when I read research that indicated uncontested support for it. My partner of 10 years and I met with an IBCLC who further confirmed that this was the route for us. (Though my partner was involved in my decision, a bias that I wish to note here is my strong belief that a woman should be able to choose how she wants to use her body. This can both fuel and contradict my passion for breastfeeding. Ultimately, I view breastfeeding as a choice a woman should make for herself and, ideally, lack of systemic breastfeeding support should not compromise this decision.) I then purchased several books about breastfeeding and pursued related education in classes through my local hospital. I also prepared by buying clothing and equipment conducive to breastfeeding and milk expression: I had come to learn that breastfeeding can be challenging and wanted to prepare by having tools available.

With regards to my immersion in the field, I have been and continue to be involved with educational and personal ventures related to the areas of research outlined in this study. I breastfed my daughter beyond 2 years of age as recommended by WHO. I was an active member of the local community's Breastfeeding Coalition group before moving out of state for internship. I am also occasionally attending the local La Leche

League International peer support group. I continue to be an active reader and participant of the group's Facebook page along with other breastfeeding support and educational pages. In May 2014, I completed my Certified Lactation Counselor training and am currently undergoing the re-certification process.

I appreciate the act of breastfeeding for many reasons. I love that it enabled my daughter to be nurtured physically and emotionally, and was also a very connecting and positive experience for me. I am also well aware and grateful that my breastfeeding journey has been smoother than most others. I was able to initiate, establish, and maintain breastfeeding due to the immense support of many, such as my partner, mom, academic program faculty and clinical site supervisors. I did not encounter many of the barriers of breastfeeding that the research discusses such as lack of education, resources and support, perceived low milk supply, and workplace restrictions. Within about a week of the birth, the pain resulting from a poor latch had mostly dissipated thanks to the help of the WIC IBCLC who heroically answered a panicked Saturday phone call. Soon after my daughter and I were able to gradually get into a groove and breastfeeding became a routine, timely, and rewarding task.

Overall, these various ventures have contributed to my knowledge and passion of breastfeeding and have also allowed me to become aware of factors related to breastfeeding support. Along with my experiences, the notion of support, as well as my existing interest in romantic relationships research inspired me to engage in the present research. Thus, I continue to learn about this study's phenomena of interest both experientially and through informal and formal resources. Throughout the duration of the study, memos, field notes and self-reflections related to these activities were recorded per

CGT protocol (Charmaz, 2006, 2014) due to their relevance to the current study. In doing so, my views and experiences were made conscious and tangible. It is my hope that by doing this, I minimized the impact of my bias on the construction and administration of the interview, and coding of the interview data. Regular meetings with the research team members also aided in this process.

CHAPTER IV

RESULTS

This chapter provides an overview of the results and lists the focused codes and initial model that address the interaction between breastfeeding and the partner relationship. Eight first time mothers who were partnered, exclusively breastfeeding, and between 3 to 8 months postpartum were interviewed. Additional demographic information such as participants' relationship and employment status, and age of infant are noted in Table 1. Mothers were asked questions about their experiences with breastfeeding, the transition to parenthood, and their relationship functioning and satisfaction. They were also asked to share specific examples, general perceptions, and to reflect on emotions, thoughts, values, and opinions. Interviews were semi-structured in order to standardize coverage of the main topics, as well as to enable participants to flexibly respond and spontaneously introduce unique and self-initiated ideas and topics.

Interviews were transcribed and analyzed using constructivist grounded theory (CGT) method (Charmaz, 2006, 2014). Analysis involved line-by-line initial coding and then focused coding in order to highlight richer and more complex themes. Due to the semi-structured nature of the interviews, focused codes that emerged were both intentional areas of focus of the interview, as well as themes based on participant answers. Interview questions were modified as new responses shed light on areas that were not initially explored and further analysis allowed for additional focused codes to

emerge until these categories were saturated. Saturation was reached at the 8th interview. Following this, through axial coding, the initially identified themes led to the development of a story, or a model of the participants' experiences (Charmaz, 2006, 2014).

Though the study aimed to uncover the process of how breastfeeding and partner relationship satisfaction and functioning are intertwined, it is necessary to first uncover the context of these processes. It is not possible to explore mothers' perceptions of this interaction without addressing how the mothers perceived two very new experiences: breastfeeding and the transition to parenthood. Bypassing this step would increase risk of imposing my biases and/or previous theory and research and thus impose a superficial framework on the current study's participants. This would contradict the spirit and methodology of qualitative research and constructivist grounded theory.

An additional rationale for providing thorough results of participants' perceptions of breastfeeding and the transition to parenthood is the richness that emerged in each of these domains. As I progressed through the interviews, it became increasingly apparent that the intensity and challenging nature of both breastfeeding and the transition to parenthood had significant impact on the core of these women's identities. In general, mothers had more to say about the intrapersonal process of their journey into motherhood than I had anticipated. They often spontaneously expressed how parenting and breastfeeding experiences were infused in and altered many domains of their lives, from cultural and systemic levels to their internal emotions, cognitions, and values. In addition, changes occurred over time. Therefore, it is reasonable that not all such aspects would have salient relevance to their partner relationships. Though their narratives were often

spontaneously inclusive of their partners, their focus was not always targeted on the relationship. As a result, while I maintained awareness of my research question throughout the interview and analysis process, I avoided superficially inflating emphasis on the partner or the relationship. Presenting the women's views on breastfeeding and the transition to parenthood establishes a context for introducing partner involvement that portrays the women's raw experiences accurately and meaningfully.

Given the general homogeneity of the sample, it is important to reiterate that CGT strives to uncover themes that pertain specifically to the experiences of the participants, and those of similar demographics. The inclusion criteria for the study required that participants be first-time mothers in a committed relationship with an individual who was considered the infant's other parent. Throughout their responses given in the demographic surveys and interviews, all women identified being in very committed, satisfying, and close relationships with their partners. The average relationship duration was 8.65 years, with the shortest duration at 3 years, 4 months and the longest at 12 years, one month. In addition, all participants reported having an education level of at least a bachelor's degree, with all partners having at least an associate's degree. The average participant age was 27.5 years and ages ranged from 19 to 33 years. All but one participant identified as white. Lastly, most mothers expressed that they held an expectation that they would successfully breastfeed from before the birth of their first child. Thus, it is important to note that the themes uncovered are particularly generalizable to mothers who have similar demographics, values, and relationship variables that are similar to those of the participants in this study.

As indicated above, in order to provide an overview and context for the main research question(s) of this project, broad categories of breastfeeding and the transition to parenthood are presented first. They are followed by an in depth exploration of the interaction between breastfeeding and the partner relationship is presented—the central focus of this project. Lastly, a model for how breastfeeding and the partner relationship are intertwined is proposed at the conclusion of this chapter.

A pseudonym was selected for each of the participants and identifying information has been omitted or altered to protect the participants' identities (see Table 1). Partners and babies are typically referred to as “partner” and “baby” respectively, rather than by name. All participants identified being women in relationships with male-identified partners who were also identified as the biological parent of their child. I use the terms “mothers,” “women,” and “participants” interchangeably. Participant quotes are included to provide a rich context and to honor their experiences and the significance of their spoken words and tones. In the cases where an ellipsis is in the quotation (“...”), to manage space constraints, a portion of the transcript deemed redundant or that does not otherwise alter the context of the included quote has been removed. Though the *Publication Manual of the American Psychological Association* (APA, 2009) does state a format for block quotations, it does not make recommendations on how to present direct quotations from participants. Therefore, the format used in this study follows guidelines put forth by researchers Cordon and Sainsbury (2006) who interviewed qualitative researchers on their preferred methods of presenting qualitative data.

Through the analysis, three main domains were uncovered (see Table 2): Breastfeeding, the Transition to Parenthood, and the Interaction of Breastfeeding and the

Partner Relationship. The Breastfeeding domain includes the focused codes: the decision, expectations, initial experiences, struggles, everything got better and easier, breastfeeding changes how your body interacts with the world, perseverance, commitment to continuing, breastfeeding in public, body image, and work issues. The Transition to Parenthood domain includes the focused codes: coordinating a new routine, outside support, positive experiences, adding this third life, striving for balance, figuring it out, intentional communication, teamwork, conflict, intense mood and anxiety, and minimization of distress. The Interaction of Breastfeeding and the Partner Relationship domain includes: the impact of breastfeeding on physical intimacy, the impact of breastfeeding on emotional intimacy, partner emotional and practical support of breastfeeding, and partner’s lack of support of breastfeeding. Focused codes where partners had less involvement are presented in an abridged manner as they have less relevance to the crux of the study, however they are included for context.

The final chapter will outline the axial coding procedure which was conducted to link themes and develop a model that represents the participants’ experiences. This model is titled Alignment and Attunement: How the Partner Relationship Facilitates Breastfeeding and Family Cohesion.

Table 2. Domains and Focused Codes.

Domain	Focused Code
Breastfeeding	The decision Expectations Initial experiences: “How to get things in the right place” Struggles “Everything got better and easier” “Breastfeeding changes how your body gets to interact with the world”

Table 2 cont.

Domain	Focused Code
Breastfeeding	Perseverance: “Willing to go through any and all pain” Commitment to continuing Cultural influences Breastfeeding in public Body image: Aversion, acceptance, and appreciation Work: Issues with accommodations and identity
Transition to Parenthood	Coordinating a new routine Outside support Positive experiences “Adding this third life...finding the extra love and energy” Striving for balance Figuring it out Intentional communication Teamwork: “When things are really good, everything is just in sync” Conflict Intense mood and anxiety Minimization of distress
Interaction of Breastfeeding and the Partner Relationship	Impact of breastfeeding on physical intimacy: <ul style="list-style-type: none"> a. Breast issues b. Fatigue and loss of ownership of body c. Hormonal changes d. Time constraints e. Partner response and support <ul style="list-style-type: none"> i. Humor ii. Positive iii. Mixed f. Partner’s view of body g. Openness h. Resolution <ul style="list-style-type: none"> i. Alternative affection ii. “Working on it”

Table 2 cont.

Domain	Focused Code
Interaction of Breastfeeding and the Partner Relationship	Impact of breastfeeding on emotional intimacy Partner emotional and practical support of breastfeeding <ul style="list-style-type: none"> a. The integral role of the partner b. The shared decision: “Always in the plan” c. Latent agreement: Being on the “same page” d. Overt emotional support e. Overt practical support f. The partner as an advocate Partner’s lack of support of breastfeeding

Domain 1: Breastfeeding

The first primary domain of the interview explored participants’ experiences with breastfeeding. Included in this domain were the following themes: the decision to breastfeed, expectations, initial experiences, struggles, everything got better and easier, breastfeeding changes how your body interacts with the world, perseverance, commitment to continuing, breastfeeding in public, body image, and work issues.

The Decision to Breastfeed

Many mothers reported that their decision to breastfeed was due to perceptions that breastfeeding is the primary or default method to feed an infant, rather than a decision that required an extensive decision-making process. All mothers reported that knowledge of the benefits of breastfeeding was the primary reason they chose to breastfeed. Most mothers reported that family influences and exposure to breastfeeding in families was influential in their desire to breastfeed. All mothers reported that their partners were immediately supportive of this decision, with little discussion and

education required. In two cases, fathers were more enthused about breastfeeding than the mother was.

Noelle shared how breastfeeding was the only option she was aware of:

I just thought in my head that this is the only way to do it...In my family it was always kind of known that we were going to go to college, it wasn't really an option - so always sort of viewed that that was what I was going to do. It's the same kind of thing.

Idina shared that she had known she would breastfeed based on seeing it in her family:

My mom is an OB nurse so I really lucked out there and she helps women breastfeed all the time. And it was something I had really wanted to do - I had seen it, it was something that I grew up with, so it was something that I really wanted to do, or at least try.

Alternatively, Lee had also easily determined she would breastfeed, but was aware and worried that her plans might not happen as successfully as she hoped:

It was never a question for me if I was going to breastfeed or not. I really wanted to...I've known for so long the benefits of breastfeeding are so much...and I've heard so much about the bond being so wonderful with the baby when you're nursing...I was going to be really upset if I couldn't...I've also just always wanted to be that providing source for him - I want to not just give him a bottle or something that a store makes if I can help it.

Francis reported her reasons for breastfeeding:

With my (breastfeeding) friend I saw how convenient it was... The class really taught me that it was better for my baby to have breast milk. If I was to use formula, I didn't want to wonder if I was giving her enough breast milk to give her the antibodies so I was determined to exclusively breastfeed.

Ann noted her desire to breastfeed stemmed largely from viewing it as “natural”: I always knew that I was going to at least try...at least 6 months...I did a lot of reading, I'm an internet junkie when it comes to topics or things that I'm dealing with...So I knew I was going to do it, cost-effectiveness and best for baby were some of the factors that made me want to do that.

Teresa noted that with research and education, breastfeeding was also an easy decision:

We took a lactation physiology course while I was pregnant...the outcomes for breastfed children are better - the antibodies, the gut development that happens, it was a pretty science-based decision for me. My husband and I were both bottle-fed exclusively so there really wasn't any maternal support for breastfeeding, it was pretty much our own decision...To some extent, it may sound petty, but the fact that my mom didn't bother me enough that I wanted to.

In contrast to the previous participants, Marie noted that though she had always planned to try breastfeeding, she considered that it might not work out:

I always knew I wanted to try...as I was pregnant I became aware of the fact that it might not work out and just kind of prepared for that...The plan was to do the first feeding after he was born and I was going to offer a bottle of formula if it just didn't take. We didn't really think too much about it.

Grace was the only mother who noted that she had initially planned to bottle-feed due to wanting her partner to be involved in feeding:

I was going to bottle-feed because I wanted my partner to be able to feed too and I thought it would be easier on me. But then I just did a lot of research on the internet and I had a couple of books, and just all the benefits of breastfeeding - I thought for me it would be selfish to not try breastfeeding out.

Expectations

Mothers were asked specifically about the expectations they had about breastfeeding before the birth of their baby. Most indicated that their actual experiences diverged from their expectations. Several women noted that the preparation and research they did prior to experiencing breastfeeding was helpful to learn about the breadth of issues that might arise. A few women reported feeling anxious and uncertain prior to breastfeeding, while a few others noted feeling confident due to having seen people breastfeed in their family and believing it would work out for them as well.

For example, Ann reported:

I did the (hospital) breastfeeding class...I think it did probably help that I knew there would be a lot more challenges, that it's not that easy, you definitely need to give it time, it's not going to happen right away.

Initial Experiences: “How to get Things in the Right Place”

All mothers were asked about their birth experiences, as well as their initial experiences with breastfeeding. All mothers birthed their infants past the 39-week mark of gestation and therefore their infants were considered full-term according to the American Congress of Obstetricians and Gynecologists (ACOG, 2013). All mothers

delivered in a hospital, with seven delivering vaginally with an epidural for pain management, and the eighth mother delivering by emergency caesarean section following an induction at 42 weeks. All mothers attempted to initiate breastfeeding immediately or within approximately two hours following the birth. All mothers reported having hospital staff being involved with their initial breastfeeding experiences including nurses and lactation consultants. Other interventions and resources are noted within this section to provide context. These experiences varied greatly and therefore were not coded separately.

All mothers expressed overcoming some difficulty related to their initial breastfeeding experiences. These experiences are noted here ranging from least negative to most negative, as perceived by the mothers. Marie shared:

It's been pretty easy, my milk came in on day 2 so there was never really a lull or anything like that. He was able to latch so it's been really straightforward from the beginning. It took me a while to figure out how to get his mouth open wide enough. The public health nurse helped me - he was feeding well but it was a little bit painful for those first 5 days until we figured it out.

Grace reported doing skin to skin immediately following the birth and noted her daughter breastfed successfully within 30 minutes. She experienced discomfort which led to the use of a nipple shield, but perceived her initial breastfeeding experiences as positive:

When she was just first born she latched on right away - no problems...She literally changed boobs all day because she was eating for a really long time. And

then her latch started getting bad so we had to use one of those nipple covers...I got a lactation consultant to help get it back to not using the cover.

Idina similarly shared that her son also immediately latched successfully.

Following his circumcision he was spoon-fed expressed colostrum due to his fatigue.

Idina talked about the physical pain she experienced for her first 3 weeks of breastfeeding:

The first 3 weeks were horrible - it hurts and you're exhausted and your child is eating all the time. And it's overwhelming because you've got this new baby and you're trying to figure a new life out...When you're nursing, they are still attached to you all the time...There was a point at like 2 weeks my nipples were so tender and so sore...There were times when I would put off nursing him...After about 3 weeks it just got easier and normal.

Ann initiated breastfeeding her son following one hour of skin to skin and after her partner briefly held him. She noted using a nipple shield immediately and feeding her son colostrum with her finger at the recommendation of hospital staff:

Right away I started with a nipple shield because I had fairly flat nipples and pretty large breasts too...He's never had a very good latch...I was super overwhelmed that my breast was larger than my baby, kind of like holy cow, it seems weird and difficult. He got what he needed but it was a lot a lot of work...I definitely needed my Boppy, needed an extra hand to hold my breast, to hold him, it was a lot...I only used the nipple shield for 2 days and then I stopped.

The following mothers spoke about various challenges with breastfeeding that were linked to other common birth and baby medical issues including: jaundice, tongue-

tie, slower weight gain, and fluid retention. Noelle's daughter was born with "severe jaundice" and was in the NICU for 3 days following the birth:

We had to supplement with formula while we were in the hospital...So that was really tough for me...Like why is my body failing me you know?...I had a really great lactation specialist when we were in the hospital...To not get physical affection much up front - that would have been probably nice to be able to hold her in my arms and get more comfortable with each other that way instead of just - pick her up put her on the boob and then I have to put her immediately back in there. That was pretty tough.

Lee shared about how her baby's ankyloglossia (tongue-tie) was diagnosed due to a painful latch and treated when he was 5 days old:

It was pinching throughout the entire nursing session. That made a world of difference as far as my comfort...he can move his tongue better...The nurses helped to establish a good latch.

Francis shared her initial breastfeeding experience:

When I first had my baby, they took her out and put her on my chest and within 2 minutes she was already rooting to eat, which was fascinating to me...It didn't get painful until like a week later when it was excruciating...I got mastitis 5 days into breastfeeding which was extremely painful because I was also engorged so that was rough.

Francis also spoke about challenges related to slow weight gain, and being advised supplementing with formula and fears that she would be forced to check her baby into the hospital:

By the time we left the hospital she had lost some of the weight as is normal...The doctor that dealt with weight gain issues - she actually talked about checking the baby into the hospital. I nearly lost my mind because she made it sound like it wasn't an option; that she would be taking my baby from me... And I found out later (from the hospital lactation support group) that they actually can't do that, you can say no. But as a first-time mom, I didn't know that. It was scary.

Teresa spoke about her recovery and the impact her caesarian section had on breastfeeding initiation. She also expressed her frustration with a nurse who fed her daughter formula without her permission, while Teresa was sleeping:

It started out really rough. I had a c-section so they used a lot of fluids and basically puffed me up so much that my nipples were flat and baby could not get a latch at all for about 10 days...The lactation consultant recommended pumping...Then we were able to get her latched with a nipple shield which then became problematic because her weight gain wasn't fast enough...The beginning of week 3, she latched naturally and it's pretty much been golden ever since. But it started out awful! It was just hard! And stressful! And not at all great!

Ongoing Struggles

Mothers expressed various issues and concerns related to the following: pumping, nipple shields, milk supply, pain, and time. Though all mothers reported challenges following the breastfeeding initiation phase, the duration and severity of such challenges varied.

Pumping struggles. Six of the eight mothers reported using a breast pump so that their partner or a caregiver could feed the baby when they were not available to do so.

Most mothers expressed disdain for pumping. For example, Idina expressed frustration about her mother-in-law potentially over-feeding her son which necessitated her to pump more frequently. In addition, she was met with resistance at her new workplace when she requested that they provide a space for her to pump that is not a bathroom, as required by law:

I definitely dislike pumping, that's the biggest downfall at work. I think that if I stayed home I could nurse like 6 babies all day long and I'd be fine with it (laugh). When you're nursing there's emotions and there's comfort and you're hugging him and you're together...Pumping feels more sterile, more like a task and less like bonding.

Ann also pumps at work and identified her “biggest stressor” related to breastfeeding is her son’s lack of interest in her expressed milk:

He has been sick and teething and there’s been a lot of reasons...Sometimes he eats a lot during the night and then sometimes he sleeps good, so I don’t know, I’m trying to keep up with my supply. I hate pumping at home but today we got home and I was really full and he didn’t want to eat so I had to pump because I needed to.

Lee noted experiencing pain from pumping and its impact on breastfeeding:

I don't enjoy pumping at all...It causes me soreness and cracking and things like that...I've just been trying to find different positions with holding him when I nurse him afterwards to ease the pain of the sore spots.

Teresa described the stress of hurrying home to her hungry daughter. Her gripe also speaks to the demand that breastfeeding imposes on mothers which is further explored in the section on breastfeeding is isolating section ahead:

She's still eating every 3 hours and town is a half hour away so that gives you 2 hours in town and then an hour drive...If I have him (partner) give her the frozen milk then we're depleting the milk stash and then there's a whole cycle - I have to pump and get my pumping supplies and yeah - there's always this anxiety of getting home in time so she can eat.

Marie also spoke about her aversion toward pumping:

It's just kind of a hassle, you have to just sit there, it's such a big loud, obnoxious machine. Yeah, I don't love it.

Nipple shield struggles. Francis was also encouraged to use a nipple shield and wondered if this had deterred her daughter from learning to latch correctly:

That might have been the reason why she keep injuring my nipple, because she was eating with the shield. And it was terrifying if I forgot the shield and I had to feed the baby, she would just scream. Oh, it was horrible, she was starving and here I am with a boob full of milk and she would not drink it without the nipple shield.

Milk supply struggles. Teresa expressed concerns about her expressed milk supply not meeting the needs of her daughter:

She's taking two 5 ounce bottles a day while the nanny is here and I can't pump that much yet, I get like 8 ounces, so that discrepancy has given me a little bit of

stress. If we don't get my supply up just a little more, it's eventually a losing battle that we will run out of stored milk.

Marie also spoke about milk supply struggles:

I wasn't sure if he was eating for short periods for times because he was over it and wanted to wean...or if it was because I wasn't supplying. I talked to my sister-in-law about it and she suggested Domperidone. And it turns out that he would actually stop feeding because...I wasn't producing as much. So I went on the Domperidone and it climbed back up.

Noelle shared:

The idea that my body might not be able sustain my daughter's nutrition needs is a little bit of a nerve-wracking thing in my mind. I started taking fenugreek, it's an herb that helps milk production.

Infant weight gain struggles. Noelle also shared concerns of her daughter's slower weight gain:

She has had a little bit of a hard time gaining weight and so that's been a little frustrating for me. I'm hoping that we're not going to have to, but I'm okay with it if we have to start supplementing a little bit of formula if she's not gaining weight.

Physical pain. Ann discussed how she believes having large breasts have made coordinating a secure latch difficult and this has had implications on her physical comfort. When asked how her breastfeeding experiences could have been more positive, she responded:

Smaller breasts (laugh), that would have helped with coordination. Yeah, if I didn't have to feel like it was such a juggling act...If I had my Boppy I was set

but if not we had a problem... That's one benefit of formula feeding, it's a lot more portable, or easily accessible... I was in a really uncomfortable position to get it to work so that would be an issue too – the pain, I would get a sore back and neck.

Francis described the pain she experienced from latching:

You have to do it so many times a day and this child is depending on you to eat and every time you feed it, it hurts like crazy. So it was also the stress of knowing that every couple hours this baby needs to eat again and it's going to hurt - the anticipation and the pain... It wasn't until maybe four months in that I can say that I was 100% pain free nursing.

Lee reported experiencing pain as well:

I'm guessing it was a plugged up duct or something. They say you can feel the lump of the duct but I didn't - I couldn't feel it but it was certainly a pain. It was like that initial latch pain all over again on one side.

Struggles with time. Teresa spoke about the time-consuming nature of breastfeeding:

She spends as long as you'll let her - right now she's just chilling at the boob and she'll be there the whole interview probably.

Noelle perceived breastfeeding as being more time consuming than bottle-feeding:

It does get a little frustrating sometimes 'cause breastfeeding - you definitely eat more often than bottle-fed babies - it's something have to plan for.

“Everything got Better and Easier”

Though mothers identified a host of ongoing challenges related to breastfeeding beyond the initial few weeks following the birth, most mothers reported feeling more comfortable and settled into the breastfeeding routine at the time of their interview.

Noelle expressed:

She was able to latch on, I didn't have struggle with it too much...It's definitely a learning process for both her and me...I feel really, really blessed that for the most part me and baby have had a good experience with it.

Idina noted:

Once I got past the 3 week mark, everything got better and easier and now that we're further into it, I love that in the middle of the night I don't have to get up and go make the bottle and burp him - that I just pick him up, go in bed and nurse him.

Lee shared:

As far as him eating and gaining weight and everything it's always been really good. I'm surprised at how well that is going. I make a good amount of milk, I haven't had an issue with supply or anything like that...I love the bonding time and I love nursing him.

“Breastfeeding Changes how your Body gets to Interact with the World”

Mothers shared the following experiences when asked general questions about breastfeeding. Along with a sense of settling into the breastfeeding routine despite various challenges, participants spoke about how breastfeeding impacts various domains of their lives and systems they are a part of. For some mothers, the act of breastfeeding

temporarily removes or restricts them from systems that they belong to, while others spoke to more permanent changes.

Grace shared how she is perceived as the default caregiver for her daughter:

I just feel almost a little left out, I guess. I love taking care of her obviously but it just seems that he (partner) gets to take breaks a lot more than I do and he doesn't have to ask me to watch her, it's just assumed that I will be taking care of her all of the time. It just kind of feels almost like it's not fair...She doesn't take a bottle yet – she's been refusing – so he can't feed her and he thinks when she is fussy she's hungry and that she needs to breastfeed all the time, even though that's not really the case.

Marie also commented on her son's refusal of bottle-feeding and its impact on her:

It prevents me from taking a nap or to have my partner feed him...We wanted to go to a concert one night and we left him with my mom...He didn't really take the bottle, he just cried and he wouldn't sleep...I spent a good chunk of the night worrying about whether or not he would feed.

Teresa also spoke about the demanding nature of breastfeeding:

When she kind of gets into these - "I want to eat nonstop for 3 days" - those can be a little annoying because if I want to go do something else I'm stuck watching Netflix while she binge eats like a kid at a candy store (laugh). That can be a little frustrating and boring...

Teresa also expressed how the passive nature of breastfeeding impacts her perception of how her body functions:

It was a really startling thing. I used to think that woman who were breastfeeding were women like me - strong women - but then suddenly you feel like this very confined, sitting person all the time. It definitely changes how your body gets to interact with the world.

Lee also spoke to issues related to restrictions in “freedom”:

There is a reduction in freedom - like if my partner wants to go off and do something, he can. But I have to think about - “do I need to bring my pump?” or “do I need to have my apron?”...If we were to go out I have to prepare and plan, make sure that there's frozen milk and that whoever's watching knows how to thaw it and all that kind of stuff.

Another way that breastfeeding is perceived as confining is related to societal views about breastfeeding in public. Mothers noted varying opinions related to this and as such an expanded focused code related to breastfeeding in public will be addressed in a later section. Grace spoke about how negative comments made by close friends regarding breastfeeding elicited feelings of isolation:

Before we were both more free...Now I like just staying home and he still wants to be hanging out all the time and doing fun things where as I don't as much - especially with our friends because none of them breastfeed. I usually have to go to the bathroom to do that because they're not comfortable with me doing it in front of them, even with a cover, they think it's weird...It's just uncomfortable and kind of makes you feel left out.

Francis and Ann also spoke to how breastfeeding outside of the house relegates them to the sidelines. Francis shared:

It doesn't matter what kind of cover I put on that child, she will rip it right off.

There is no covering, she just does not care, she wants that thing off of her face.

So now I just go nurse her in the car or something.

Ann expressed similar experiences of leaving public environments to nurse in more private settings:

He's been such a distracted nurser lately that it really limits my options. I don't think he would nurse in public unless he was *starving*...He wants to look at everything and has better things to do or he'll like latch for a minute and then he's done...So I have to nurse in his room, in the dark, with the door closed, which is very very limiting and kind of isolating. It's stressful.

She also spoke about how breastfeeding has limited her activities:

My partner has gotten into ice fishing the last couple years, and I like to fish as well but breastfeeding kind of hinders that because it's like – do I bring my pump or do I bring him with which doesn't really work and then if we were to do that on the weekend...weekends are my time with him. I know it would be healthy to...have more date nights...but it's really hard for me to give up that time.

Further, Teresa described how breastfeeding feels isolating due to her mother's preference that she leave the room when she breastfeeds. Teresa noted her upcoming plans to visit her parents for 5 days:

Five days there and this kid eats nonstop so great, I'm going to sit in a corner of my parents' house, that'll be fun.

Perseverance: “Willing to go through Any and All Pain”

As previously presented, all mothers experienced breastfeeding challenges, and all mothers made the decision to continue breastfeeding and persevered to overcome these challenges. As a reminder, study criteria required that breastfeeding was the infants’ primary source of nutrition. All mothers identified experiencing one or both of the following mindsets that facilitated this persistence. The first was that mothers viewed breastfeeding as the “only” option and therefore giving it their all was considered the only way to continue. The second was self-efficacy and “mother’s instinct” which enabled mothers to strongly believe that they would succeed if they persevered. It is important to note that though the barriers they experienced are certainly factors in breastfeeding termination, the women in this study were physically able to breastfeed. Their persistence in breastfeeding is therefore both a testament to their commitment to breastfeeding, as well as their ability to have the physical, psychological, and social means to do so.

It is imperative to note that although one of the standard interview questions is how committed are you to continuing breastfeeding, this question was intentionally not asked until after women had shared their experiences with breastfeeding in order to avoid potential for impression management or other biased answers. Though all women identified experiencing challenges related to breastfeeding, I did not directly inquire about how or why women chose to continue to breastfeed when they experienced difficulty; their comments related to this were provided spontaneously.

Lee had noted having nipple pain due to her son's ankyloglossia. She expressed: I was more than willing to get up in the middle of the night and nurse him because with my motherhood instinct kicking in full throttle it was really fun and exciting to.

Idina faced challenges finding an ample place to pump when her work offered a bathroom to use:

There's a (local) La Leche League group on Facebook and I had posted on there... One of the gals said a comment along the lines of, really make sure you say something because this could make or break somebody else's nursing relationship. And that was more of a motivator. I knew no matter what, even if I had to pump in the bathroom, I was going to do it.

Lee battled nipple pain for several weeks and shared:

Pumping is not enjoyable at all and then going home to nurse him after I've being sore from a pump... But I'm willing to do absolutely whatever it takes to continue nursing him or giving him breast milk. I'm one of those that's willing to go through any and all pain as long as I can keep him happy and eating as well as he can.

Similarly, Francis had experienced nipple pain for several months:

I remember feeling like - probably because I'm a stubborn person - this was what I wanted to do and I wanted that bonding experience. Occasionally in those first few months I would have less pain and I did feel that bonding feeling... And that was quickly changed once she gave me a blister. But then I guess I had already

tasted it so it was like, oh I know what it feels like and I really want to have that long term.

Francis also demonstrated perseverance despite her perception that a hospital intervention hindered her ability to establish a good latch. In her quest to find a solution to her pain she sought help from several lactation consultants and breastfeeding support group to no avail. Finally she found a tool called a nipple everter that immediately resolved the issue and led to a pain-free latch.

Teresa spoke about her perceptions of continuing breastfeeding in the face of milk supply concerns:

That's been a little bit of a new stress. I just remind myself to stay confident and it'll happen, we'll get there...I have no doubt that we'll get there, we just have to give it time.

Noelle also strongly expressed her view that she perceives breastfeeding as the only option:

Part of my ability to stick with it was just the fact that...I didn't really have in the back of my mind that there was another option.

Noelle also spoke about how her baby's health complications also helped her persevere:

Because we did have to be so stringent with it (baby's feeding schedule), I got it in my mind like, we got to make sure that she's getting the best. I'm sure that influenced my will to keep going with it and not get frustrated at it because I knew that she really needed it.

Similarly, Idina expressed that she also continued to perceive breastfeeding as the only option:

I really felt strongly that I really wanted to be successful at it, I really wanted to do it, “I'm just going to go into it like I don't have another option and then figure it out as we go.”...Now that I'm nursing him, seems that every month that I make it, I'm like, okay, made it through that month.

Teresa had shared about her challenges with establishing a good latch and noted that her knowledge about the benefits of breast milk helped her to keep trying, along with some other motivational factors:

(I was) very determined...Our doula always says it's your baby's birthright, it's something that your child deserves from you is my opinion...Knowing that she was getting breastmilk from pumping was really important...You hear that they'll get used to the bottle and never go back to the breast - and the lactation consultant was like “no, we can get her back to the breast, it will be fine.” I think that kind of confidence on her end helped me stay confident this would work.

Francis elaborated on the difficult phase when she was told by hospital staff that her baby was not gaining weight at the rate they preferred:

She started gaining weight and...I was getting more comfortable with knowing her hunger cues and how long of a feeding she needed, because all of this is so up in the air when you haven't done it before. So I was...confident enough to take her off of the formula.

Commitment to Continuing

Following all of the standard questions of their experiences of breastfeeding, mothers were asked how committed they were to continuing breastfeeding in the future with their current baby. Given that inclusion criteria required mothers to be currently breastfeeding, it is not surprising that even the most ambivalent mothers were committed to continuing breastfeeding for the time being. Most mothers answered that they planned to continue breastfeeding for one full year and to wean after this time, but their level of certainty about when to wean varied from some who were very certain they would wean at around one year, while others were uncertain about how much longer they would continue beyond this point.

For example, Idina shared:

I really want to make it to one year...A year seems like a really good time for me to be done and maybe let him nurse at night or comfort nurse if he needs to a little bit longer than that. If I can make it to a year, I would consider that a success and probably try to get some time having my body back to myself.

Facilitating Factors

Though mothers were not specifically asked what helped them with breastfeeding other than their partners, all mothers referenced people, circumstances, or experiences that facilitated their ability to successfully breastfeed. Examples of informal resources included online support groups, friends, mothers, sisters and sisters-in-law. Examples of formal resources included lactation consultants and nurses. Lastly, examples of circumstances that were identified as facilitating breastfeeding included being able to stay at home and being able to get more rest.

Cultural Influences

Mothers were asked about their exposure and experiences of cultural and societal messages about breastfeeding. All endorsed having such influences and reflected on the varying degrees of impact they perceived such messages to have on their experiences of breastfeeding. Most mothers reflected cultural messages that were communicated by people close to them, as opposed to via media or other means.

Francis reported learning from her mother about how doctors discouraged her from breastfeeding her first three children. She then decided to breastfeed her youngest two children, one of whom was Francis:

I am kind of surprised that even though we are kind of a pro breastfeeding generation, not as many people breastfeed as I thought - definitely not as many people exclusively breastfeed. I know a lot of friends who are breastfeeding and doing formula - that could be what the healthcare system is pushing people toward because when I had my daughter they were really trying to push the formula with the breastfeeding.

Idina shared:

I really grew up in a culture of breastfeeding. With my mom being an OB nurse, there were a lot of times that women would be breastfeeding in our living room because they would come over for my mom to help them with something...that was normal for me growing up, and so was bottle feeding. It was never like - oh that baby's bottle-fed, and that baby isn't, it was just, babies get fed.

Breastfeeding in Public

This section explores the mothers' views on breastfeeding in public spaces. Though most states allow mothers to breastfeed in public by law, the issue remains a contentious one in our society for many reasons. Given the frequency with which a newborn eats, it is not surprising that all of the mothers spontaneously brought up the issue when asked about cultural messages related to breastfeeding.

All women endorsed breastfeeding in public as being okay for other women to do. However, most women expressed a preference to avoid breastfeeding in public. Some noted that they would use a cover but that this would pose challenges and they preferred to be as discreet as possible. Mothers commonly expressed that as their baby aged and become more active they were less likely to cooperate with attempts to be covered. Some women indicated being comfortable with breastfeeding in front of select others with a cover.

Lee shared that she is most concerned about making others feel uncomfortable: Nursing in public kind of sucks and I do use a nursing apron. I'm fine with it, I just I don't want to make others feel uncomfortable...It wouldn't bother me to not have an apron because it's easier - you don't have to fight with this thing and it's hard to get a visual on him and help him get a good latch and things like that. But I'm one of those people that cares about what other people are feeling, I don't want to offend somebody.

Grace had shared earlier about her experience with friends who were opposed to her breastfeeding in front of them. She also shared about other cultural messages:

(Compared to breastfeeding) you see just as much cleavage on billboards or walking past Victoria Secret - and no one really bats an eye at that... Now that I breastfeed I would think it was awesome to see someone feeding their baby in public. I think it's beautiful now and the fact that people get weirded out by it is really a double standard... They want to see breasts sexualized but not used for feeding a baby which is a primal thing.

Most mothers denied awareness of any type of reactions from others when breastfeeding in public. However, Teresa recalled a positive interaction while in a restaurant:

I was sitting in a booth feeding her and a lady came up to me, she was so excited saying "I miss feeding my kid" – so I've had some lovely out and about experiences where you think, oh that's great, people are good.

Body Image: Aversion, Acceptance and Appreciation

Women were asked how breastfeeding has impacted their views of their body. All women reported that perceptions of their bodies changed throughout their breastfeeding journey. Most women acknowledged the shifted perceptions of their breasts being previously regarded as sexual, to now being regarded as functional. Women identified three primary perspectives of their bodies: aversion, acceptance, and appreciation. Though these themes were acknowledged across women, how they manifested was different from mother to mother. For example, some women held these views concurrently, while others held them in different contexts and in different stages throughout their breastfeeding journey. As such, the results are presented in a mixed

format, in order to honor the uniqueness of each woman's process and to highlight examples of the sequences.

Lee and Grace shared how their "flaws" are an indication of their body's purpose.

Lee expressed:

I wanted this baby so bad and we tried so long to conceive him. So I have been so welcoming of whatever changes that my body takes...I want to lose the weight...but at the same time the little extra pudge on my stomach hasn't bothered me as much as I thought it might - because I know all that my body did to create this miracle. So I've been much more accepting of flaws.

Grace explained:

I think there are some days where I don't see it (body image) as good. I think that has to do with the stretch marks and everything. Some days breastfeeding makes me feel really empowered and in turn I see my stretch marks as beautiful. And some days are harder than others.

Marie, Ann, Francis and Noelle's stories captures how the journey of body image is not a linear one. Marie shared about how her experiences of weight fluctuations and then having a miscarriage have impacted her views of her body. She was asked how breastfeeding has impacted how she sees her body:

I had a reality check in body acceptance – when we first got pregnant we actually miscarried and I spent that summer getting to a place where I could forgive my body and accept it...Then getting pregnant successfully and being able to carry it through I was just so grateful and I was like you know what, if you don't want to look at it (breastfeeding), don't look at it, but this is a natural thing and my body

is meant to do this and this is why we have boobs and screw you if you don't see that.

In addition to acceptance, she identified feelings of insecurity about her body: I'm running three times a week and trying to eat healthy and I'm having a really hard losing weight so part of me is wondering if I don't wean will it go away and if I don't wean before I get pregnant again, will I always be chubby?... When I look in the mirror I look okay but...things aren't as taut as they were before. I was a big girl in high school and I lost a ton of weight so I've always had insecurities about stretch marks and not being super perky and stuff like that, and that just reaffirmed it now that I have a post-baby body.

She also acknowledged appreciation for what her body can do:

When you're taking your baby in for weigh-ins and watching them get stronger every day, it's neat to realize that it's you that's done that. That your body continues to produce everything your baby needs to grow and develop. It's like an extension of pregnancy, and it gave me a feeling of accomplishment.

Ann's views reflected acceptance of her breasts and their new purpose of providing nourishment to her son:

It's definitely changed my view - I always thought it was weird that breasts were a sexual type thing - now that I've used them to nourish a life, I'm like meh, that's a big deal, that's what they're for, feeding baby and not anything else, so yeah that's the purpose of them.

She also experiences concurrent aversion and amazement toward her body:

I've always had a larger chest size so that's always been something that's bothered me and then when your milk comes in, you grow even bigger (laugh) so then there is self-consciousness about that. Yet at the same time, it's kind of amazing that I can produce this milk, that myself alone can totally nurse and grow an entire human being. There's this *dissatisfaction* of oh my gosh now my breasts are even larger and then there's that satisfaction of, but look at how, before they were large and they didn't really do anything, now they're large and they're growing a human and there's something really powerful about that to me.

Before you're breastfeeding, your breasts can be more of a sexual thing but when you're breastfeeding, not as much...now I'm more like don't touch them, my milk could like leak on your face. But it's a better and more specific purpose, a more powerful purpose.

Francis also identified feeling proud of what her body can accomplish:

Growing up you find out this is part of the reason you have breasts - is to feed a baby. I guess part of it was just the natural purpose of them and wanting to fulfill that purpose and then the bond that you have when you're nursing a child. When I bottle-fed her because of the pain, the bond just wasn't the same as when she was feeding right off of my body...Feeling like you're fulfilling what she needs...kind of like a validation, like as a mother you are doing what you are supposed to be doing for this child... I guess it felt kind of empowering, like I can feed her, I can do this... In general I feel sexier about my body - it makes me sexier that I can do that.

She noted her views of the changes of her body shape:

My body is definitely different from pre-baby to post-baby. There are aspects of my body where I think, I miss my old body, but it's definitely worth the cost. I'm not thinking, oh I would rather have my body back, it's worth the sacrifice for sure... When I'm getting dressed, when I'm getting ready for the day I feel very frustrated about my body... When I'm having to go out somewhere, I'm much more aware of it and feeling much more self-conscious about it. Like the way clothes fit, like the way my body lays now is just different than the way it was before. I have pouches where they weren't before.

Noelle also spoke about the feelings related to changes in her weight:

My body's definitely completely changed after having a baby. I've always been very active and worked out... I've always heard people say that with breastfeeding you can still eat whatever you want... After I had baby I was down to 5 pounds heavier than before I was pregnant and then I gave myself a license to eat whatever I wanted and I ended up gaining weight.

She also identified that becoming a mother inspired feelings of awe and confidence in her body:

I have been so much more impressed with my body than I ever thought that I could be. You always know how babies get birthed and you know breasts produce milk, but until I experienced it, I never really realized how awesome that really is, that my body can do this. So that's been kind of a cool confidence thing too.

Teresa's experiences also speak to the three primary views of body image. She initially noted feeling generally positive:

So I have pretty large boobs, they were double Ds before she was born and they're like Hs now which I didn't know was a size until after I had kids but (laugh). My boobs have always been very sexually noticeable. Guys comment on them, friends - girlfriends will say things like oh you can get anyone you want with those boobs. I feel like they are functional, useful part of my body instead of just sex bags hanging off the front. Breastfeeding has given me a very positive body image.

She then elaborated to share her reactions toward her breasts after the birth:

The first month or so after she was born my breasts just felt like they weren't my own - not because of her (the baby). They were hard, they were lumpy, and they were sore sometimes and they were full and they...did not feel like part of my body, they felt like a foreign crazy distant thing. And then, just as sudden almost - they kind of were again normal to me. So it was a month of them transitioning from a sexual item to awfulness and then okay, now they're this functional thing that feeds the kid. It was real odd (laugh). It felt like one morning I just woke up and they were soft and they were breasts again and not these crazy angry milk-engorged monsters. But they also weren't breasts in a sexual way, they were feeding my kid.

She also shared her struggles with changes in her physical strength:

I've never felt so physically weak until the time I was pregnant and until about a month ago really where I could start building strength back. It's been frustrating...Physical strength has always been important to me, not so much for appearance but strength.

Work: Issues with Accommodations and Identity

At the time of the interview, three mothers had returned to work full time, two had returned part time with plans to increase to full time hours soon, and three mothers were caring for their babies full time. Of the latter group, one was two-thirds through her 13-month maternity leave while the other two mothers reported they plan to stay home for at least one year. Prior to the birth, all mothers had been employed full time outside of the home. When asked about changes in their routine since becoming parents, most mothers who had returned to work mentioned issues related to accommodations for pumping and changes in their identity.

Accommodations. Of the five mothers who had returned to work outside the home, four pumped at work while the fifth had to work shorter shifts due to her baby's refusal to take a bottle. The workplaces of all the pumping women were accommodating, however as mentioned earlier, Idina had to advocate to pump in a clean environment when she initially returned to work.

Identity. Women also expressed how they integrated the motherhood role with their working outside the home role. For some participants these roles became complementary after a period of adjustment once returning to work, while others chose to stop working outside the home for the time being. Marie, a high school teacher who was on maternity leave at the time of the interview spoke about how she has embraced motherhood:

Compared to being a teacher...I feel like emotionally this year has been *much* less stressful. Physically it's been tough - a few months ago it was hard, you know, nursing and it would be tough to wake up so much in the night. Now I feel more

rested and I feel like emotionally it's a lot less exhausting - my job can be *really* mentally and emotionally exhausting. Not having that makes this year so much easier because - you're tired and you're emotional but you have a baby!

Teresa shared her experience with perceiving breastfeeding as passive and how this impacts her roles in her relationship and her work:

I think I would die of boredom if I didn't have my work to keep me going when she's taking naps and all during the day (laugh).

We (partner and I) both work in the same profession so we spend a lot of time as equals in the field. I'd say that in our relationship I have always viewed us as very much equals... Breastfeeding has increased the inequity of the relationship because I'm the only one that can feed the kid - I have to sit and I have to be there and be more still and I feel more womanly where he still gets to (be physically active with work) while I'm stuck inside being the girl. It feels like, physically, I don't feel like an equal right now...It's a huge thing for me.

As a stay-at-home mother, Noelle shared about how her identity has also shifted. She too works in the same field as her partner:

At first it kind of felt like I was leeching off of him. Like I'm not making money and if I go to the store I'm like, aw I can't buy that I don't have any (money), but no I'm working too you know... This is one of the things too that I sort of feel like bad about sometimes - that I miss work because I have this daughter and I'm so excited to be home with her and so happy that I'm able to because so many people aren't able to stay home with their kids. So I feel great about that but sometimes I do miss that part of myself too. I'm more confident in that setting but definitely

having a child is the most fulfilling - I mean truly the most rewarding that I've done.

Domain 2: Transition to Parenthood

The second primary domain of the interview explored participants' experiences with the transition to parenthood. The focused codes uncovered within this category were: coordinating a new routine, outside support, positive experiences, adding this third life, striving for balance, figuring it out, intentional communication, teamwork, conflict, intense mood and anxiety, and minimization of distress.

Coordinating a New Routine

Participants were asked in an open-ended manner how being a new parent has been. Most mothers answered that coordinating a new routine and schedule was both an immediate and ongoing endeavor in their lives. Regardless of the age of the infant, mothers reported a constant need to adjust childcare, housework, work outside the home, and personal schedules in conjunction with their partner. This led to the need for collaboration on scheduling. All mothers indicated that differing expectations and rifts in communication frequently led to frustration and an enhanced need to mindfully attend to improving day-to-day functioning in the partnership.

All participants reported that at the time of the interview, their partners were employed fulltime outside the home, and had been since the birth. Six partners took between 2 to 7 days off following the birth. Noelle's partner was off work for 2 months and Ann's partner returned to work part time for about three months before returning to his fulltime schedule. As a way to accommodate her ever-changing schedule, Idina and her partner have had to explicitly plan the hours of their days:

Yesterday we sat down and went through a calendar and decided, okay, what days am I bringing my baby to daycare, what days are you bringing baby to daycare and then also we have two dogs so one of us has to kind of come home or be home at some point during the day to let them out so also making note of that too on the schedule, so we know if we need to find somebody else to let them out.

Lee expressed how her work schedule and caring for her baby have had the biggest impact on she and her partner's night time routine:

I haven't slept for 8 hours straight in 3 months...Getting ready for things or leaving to be at a place at such a time has been more challenging and we have to leave earlier and prepare to leave a half hour before you actually even intend to go.

Marie, spoke about on how she has taken on more household tasks because she is home more than her partner and this allows for her partner to spend more time with their son when he arrives home from work. She explained that one way she applies her time strategically is to combine running errands with exercise while with her son.

Outside Support

One way that several families mitigated complications with difficult work schedules and pursuit of flexibility and personal care was by seeking support from extended family members and hired childcare. However, often this was not a straightforward solution for achieving work-life balance. Most women had grandparents who were eager to help out, but did not live in-state or were only intermittently available. Most women identified wishing they had more local support to help with childcare and emotional support.

Positive Experiences

All parents expressed having positive experiences with motherhood and shared general and specific examples. Noelle expressed:

It's been the best thing - my favorite thing I've ever done in life. I know that's kind of a stereotypical thing to say...I always thought that I was too selfish to have kids since I wanted to go places and that kind of thing. But I love spending time with her now, my little buddy. Definitely a change of lifestyle but a good one.

Francis noted how she and her partner have shared joy spending time with their little one:

There's also definitely a lot of new love, new experiences. Experiencing her together, like when she does something for the first time. To be able to share that together is really nice.

“Adding this Third Life into our Relationship: Finding the Extra Love and Energy”

All mothers noted how becoming parents has required a shift from focusing on a dyadic relationship to attend to a third member of the system. This was an abrupt adjustment for these participants whose average relationship duration is 8.65 years. Participants generally felt that their pregnancy had allowed them to prepare for the change, while it seemed to take partners longer to settle into a parenting role. These issues will be further explored in later sections more specifically related to communication between partners. For now, this focused code addresses the responses pertaining to how the smallest member of the family now takes up the biggest amount of time and energy.

Ann noted:

It's just different, it was a whole new focus in our relationship, I feel like there's less communication about us, or stuff about us, we talk more about him and maybe not so much what is going on with us individually, like maybe at work.

We need to take more time to do that.

Similarly, Francis noted the shift in attention away from the partner relationship:

Going from having time together on our own to then having someone who demands literally all of your time when she's awake, it's kind of draining. We knew what we were getting into, we knew that we wanted to have a child. I think that's one of the things that helped is that because we were together for so long we got to do everything we wanted to do...just hanging out without having those responsibilities. So when the time came, we were like, yeah we're ready now, it's going to be hard - and I will admit that at the time we did not know how hard some of the times were going to be.

Idina echoed how it is challenging to share time among her two family members:

Our focus has kind of shifted off of each other to add this third life into our relationship. We were married almost 4 years before we had a son so I think part of it was like, oh we are used to it just being me and you all the time for years and years and now *oh*, there's this whole other life that is taking up our time and our energy too. It's emotional energy and physical energy and relationship energy - it's pulling energy from you, from all sorts of different areas. The hardest part of transitioning is finding that extra love, or finding the extra energy to spend on a whole other thing, especially when you're so busy and it's like, ugh I'm out of

energy. So in some ways it takes energy away from my relationship with my husband. It's like, okay, it's easier to not talk to you so that I can go to sleep early than it is to have a conversation with you after work.

Teresa expressed the shift of focus in a matter-of-fact manner:

The husband-wife interactions, the day-to-day communication and personal-ness and intimacy in the relationship is definitely decreased. The communication - it's shifted...from the focus on each other to - you don't focus on each other at all, it's just focus on the baby right now.

Grace acknowledged the importance of nurturing her relationship despite the attentiveness a new baby requires:

It's a lot different when the baby comes because your daughter's your main concern and it's not just the relationship anymore. So you gotta take time for your relationship and talk and spend time together, rather than leaving it on the back burner.

Similarly, Lee noted a value of her and her partner prioritizing their relationship while also attending to their new baby:

It's on both of us to tend to somebody else other than our relationship - it's not just each other. It's something that we need keep in the front of our minds - that each other still matters and we still do want to be with each other and give each other attention and stuff, working it into our new schedule and our lives. We know that it's important so we are putting forth a stronger effort.

Striving for Balance

Increased responsibilities and changes require new families to determine how to best manage their new priorities and new roles. Many participants shared their experiences related to seeking balance across the domains of their lives during the transition to parenthood. Throughout these endeavors, mothers realized that change is constant and being aware of their own needs, along with those of family members, is important to stay the course. Ann sounded tired when she expressed feeling obligated to uphold balance for her son despite competing demands:

It's about balancing who should be responsible for what, but I know our priorities have definitely changed, about like a clean house. Spending time with him is more important a lot of days... We try to make more time to do things together versus doing things like household stuff.

Grace also noted that date nights and combining activities are ways she can attend to her daughter and partner:

We were planning before the baby was born to do that (date nights) once a week but so far we've only done it three times... And then we also try to cuddle, all three of us... and watch movies as much as we can. We started turning the TV off at dinner... usually she will sleep so that's a good time to talk and get back to being connected.

Lee spoke about the challenges of meeting the needs of her son's nap schedule while also trying to maintain the lifestyle she and her partner had before he was born:

We're on a time crunch - we have so long until he's going to wake up and be hungry and we want to be home when he's hungry. So we do spend a lot more

time at home. We don't go to movies - we used we love going to all the time... So we haven't really done those kind of things yet but it hasn't stopped us from a lot of things like - we will go out to a restaurant here and there. So we've managed to keep a little bit of our old lifestyle while sacrificing other things.

She also touched on how maintaining her social life also looks very different now: It's like pulling teeth to get together because they have kids as well. So we'll plan something and then a kid will get sick...so it's certainly harder to maintain friendship...It's harder to get out and do things with people when you have a baby.

Francis spoke about how her baby's consistent sleep schedule has facilitated one-on-one time with her partner:

We don't get as much time as we used to have together, but...we get that time when she goes down to bed... We are just hanging out, watching our favorite show together or playing a game together or something like that. So that I think has helped us still get a little dose of what life was like before she was born pretty much almost every night.

Noelle also expressed her struggles with taking on a new identity as a parent that overshadows her identity as an active, social being:

I'm pretty independent - I love going hiking and camping and whatnot. I think the biggest adjustment for me is not really being able to go do those things if they come up, having to plan things out a little bit better...my friends will be going to do something and it's not like a kid-appropriate thing, or I don't have a babysitter so I can't go and I wish that I could.

Idina spoke to a common theme of digging deep to find energy to meet multiple demands and feeling guilt:

Sometimes I feel bad, like he'll be telling me something about his work and I'll act like I'm listening, but in my head I'm totally thinking about like okay, we need to get this ready, and the laundry needs to be washed, and I gotta bring the dogs to the vet tomorrow...I half invest my energy when I really should invest all of it.

Teresa also acknowledged how she and her partner have tried to fulfill household obligations while caring for their daughter and how fatigue makes it difficult to put energy toward the relationship:

Our relationship previously was a lot of one on one interaction, we were pretty good to be in the moment, engaged in conversation or an activity together, or *doing* a lot of things together. One of the big things now is that we are in the same room a lot and we're doing things but it's just not as interactive. One of the things we did recently was the outdoor work in the backyard and normally that would have been both of us, outside, sweating, working very hard. Instead it was him outside most of the time and me taking care of baby and intermittently he would come in and take care of baby so I could then get out and do some actual yard work which is pretty therapeutic for me. So that's probably the biggest change - the times we do have together, we're both tired, and generally less interested in talking about everything that we used to.

Figuring it Out

Throughout sharing their perceptions of the transition to parenthood, mothers often addressed their attempts to manage the changes the aforementioned routines,

balance, and childcare. This focused code more closely addressed what it means to these mothers to “figure it out” and what it looks like. On the whole, mothers expressed that their quest to “figure it out” was not an aim to solve a problem indefinitely, but rather attempts to meet the needs of their family, including themselves, and how to keep on top of ever changing demands. Ann noted that accommodating her son’s sleep routine requires constant attempts to “figure out” his needs. She also acknowledges the realization that success in one area may mean a sacrifice in another:

He’s at the age he doesn’t just fall asleep in the car seat or in the stroller when he’s tired anymore so it’s either you go and do what you need to do and have a crabby baby or don’t go anywhere (laugh)...I’m constantly thinking what can I do differently, what can I change, can I try this, should I do this, should I do that, it is, it’s a lot, it’s consuming, it really is.

Francis also spoke about the process of how she and her partner have actively tried to seek resolutions:

There's a new level of stress in our relationship and we're still trying to balance out how to figure that stress out. You have stresses in your relationship before a baby but then it's a lot of new stress so we're still kind of adjusting, still trying to level things off. There's fighting (laugh) - but it's more like we gotta figure this out type of fighting...Like if she's upset...if my husband has a different opinion on that then it gets like a juggling act of figuring out, am I right? Are you right? What should we do?...We will just try both things and not rub it in each other's face if one person ends up being right and the other one doesn't.

Idina also addressed how the constantly changing demands makes it difficult to keep up:

You think of it like a fairytale when you're pregnant, it's going to be so amazing and we're going to have a baby and then you have it and it's like oh my goodness, this is so much work...it's been exhausting but really rewarding and it seems like it's changing all the time. Like what's hard one day changes and isn't hard a few days later...When he was really little and he would cry it was like "oh no," you don't know what he needs or wants. But then you get used to him and he gets used to you, you kind of can anticipate their needs a little better.

Idina also spoke to her developing “mother’s instinct” and her belief that this allowed for her to settle in to her parent role more quickly than her partner:

It (parenting) did come pretty naturally and maybe that's because it's more natural for women in general but it just came a little easier for me - and maybe it was mother's instinct...It took him a little bit longer to get to that same point where things become easy and things felt natural and he knew what he was doing. That was something that really tested out our relationship, where it was like, oh why can't you just get that, why can't you be more help than you are right now, when maybe he was trying his hardest, so little things like that.

Marie shared similar sentiments when she spoke about how it has taken her and her husband about eight months to get “back into the swing of things.” Her partner was out of town for about half of their son’s first two months which led to the need for her to establish a routine and her preferences in caring for the baby. She explains how this caused some tension in her relationship:

When he would come home, an issue would come up and I would say well why don't you try this? And he thought it was me telling him what to do...I tried to get him to understand that it's not me being demanding, it's that I'm trying to help him out...for the longest time he felt like I was being really bossy and I felt that he wasn't listening to me... (So we had) conversations about - we are going to have this baby our entire lives, there are going to be a lot of firsts and sometimes he will be the one to figure out how to handle it, and sometimes it will be me, so don't stress if I'm the one to figure it out at first, because there are going to be so many more things.

Noelle spoke about how parenting is unlike any other task she has taken on:

Obviously it's my first time parenting so learning all these new things and figuring it out. So that's been the center of my world and it's been everything that I've been putting my effort into...It's a great adventure.

Intentional Communication

A strategy that each mother used in an attempt to "figure it out" was communication. Most mothers endorsed the heightened need to communicate more intentionally and collaboratively with their partners. Communication was largely recognized as a complex and evolving process, rather than a straightforward means to achieve a goal. In addition, most mothers endorsed experiencing frequent communication ruptures, especially early on in the transition to parenthood. Some mothers perceived communication to be a skill in their relationships before becoming parents and all of these mothers noted that the arrival of a baby forced these skills to be further honed.

Ann spoke about how “there are definitely areas we can work on” with regards to communication between she and her partner. They see each other infrequently due to offsetting work schedules. A strategy they have implemented is to be in more frequent contact:

If he’s at work I try to make sure we have a little phone call because especially when he picks him up from daycare, I like to find out how his day was and how he ate.

Noelle had worked with her husband prior to becoming a mother and had expressed missing her role working outside the home. She commented:

He is trying to keep in touch (during the work day) which is really nice. I enjoy working and a part of me kind of wishes that I was doing that. He's very good about keeping me updated if there is something going on, like he'll just shoot me a little text.

She also spoke about how in the past when she was upset with her partner, she would question the validity of her feelings and attempt to ignore them which often led to acute angry outbursts. She realized that being more open about her feelings is a way she can work through them and feel more validated:

(I’m) trying to be more open and honest when I’m frustrated and valuing my opinion. Like saying, if I’m feeling like this, I’m allowed to feel like this...he's working all day and then he comes home, he's tired and I’m like – entertain me, like hey you're home, we've been by ourselves, me and baby. So I’ve had to become more open about what I’m feeling and tell him that, like get it out and then you can move on and it doesn't just fester into a nice blowout... Before I

would have just kept getting more and more angry until we talked about things and then I would let it go.

Lee addressed how she and her partner's communication has had to become more skillful and intentional:

We have really mature, strong conversations with each other, like "will you handle this while I take care of this?"...I need to let him know this information and he needs to acknowledge that he's received that information...We communicate clearer and work together better now with him (the baby) honestly which I thought would be more difficult.

Grace shared how using a communication strategy she found online that suggested talking about disagreements only over dinner has been helpful:

It's more civil than yelling at each other across the room. Sitting right in front of each other, it's better to talk about the situation that's coming up...We definitely have to keep at it...but I think it's working.

Mothers also spoke about having strong communication in their relationships in general, and how having a baby can complicate what used to be more straightforward.

Noelle shared:

There are times that we're not good at communicating, but for the most part that's one of our biggest strengths...The baby was a new thing because we realize there's times when we're not on the same page and we're like, oh you don't think the same way as me? We sometimes realize that we make assumptions about being on the same page because we usually had been before...then we get to that part where we are like, oh wait you want me to use cloth diapers? I have no

intention of using cloth diapers...Once we realize we have a difference of opinion we just both lay out why we have the opinions we do.

Teresa shared about how she and her partner determined their parenting plans: I have pre-set things I think I should be doing, breastfeeding being one...trying to check the boxes that I feel are important in her development and our style...we both talked about that list, what was important, and identified those things together.

Teamwork: “When Things are Really Good, Everything is Just in Sync”

Mothers spoke at length about how teamwork was a core aspect of their experience of the transition to parenthood. Half of the mothers spontaneously referred to their partner as their “best friend.” All mothers shared examples of how they collaborated with their partners. This code focuses on how mothers value collaboration with their partners. These experiences were both practically beneficial, such as enhancing co-parenting efficacy, as well as emotionally gratifying. Most mothers expressed a belief that parenting has strengthened the connectedness they have with their partners.

Lee addressed how her partner is there when she is distressed and needs a break from caring for her son in the middle of the night:

There have also been times where I just absolutely cannot take him, I’m about ready to shake him or something, like I can't handle this anymore, I’m going to throw this kid through a wall and my husband will absolutely get up and help.

Francis commented on how she and her partner connect by sharing activities together:

When things are really good, everything is just in sync and we are both happy to do what the other person wants to do and we're also excited to do that thing. We have very similar likes and dislikes which makes it a lot easier, so when things are going well it's basically like skipping through life with your best friend and now you have a baby and it's like, oh let's go to the park, and oh let's go do this...He's definitely my best friend. I tell him absolutely everything. He knows me better than anyone else - every fault and every fear that I have. He is the one that builds me up and cheers me on.

Noelle echoed these sentiments when she expressed her perceptions of her closeness with her partner, and noted ongoing efforts to be more genuine and open with her emotions:

He's definitely the person I feel closest to...He is my best friend and that's always been something I've loved about our relationship. We are friends first. We go out and have fun, we like to laugh, it's not always so serious.

Similarly, Marie shared:

We've been best friends...That's the kind of closeness I want in a relationship - we can talk about *everything*, there is nothing that I would tell someone else that I wouldn't tell him...If there is something we want to hash out, or bitch about anything, we are always each other's go to and so if I need advice on anything, I'll go to him. I might not take his advice (laugh).

All of the mothers in the study had been in their relationships for over 4 years, with most relationships exceeding 7 years in duration. The long term nature of the relationships and the familiarity participants had with their partners was particularly

evident when they spoke about how teamwork was integral to their approach to parenthood. Marie noted that following an initial period during of frequent conflict, she and her partner collaborated on how they could better co-parent their son:

For a while there, we would argue about everything...One of the issues that would come up is we would be trying to get out the door and I would want his help, because during the day I would be on my own so I couldn't ask him for help...Now it feels like more than ever a partnership where you're a team, and he helps with putting baby in the car.

Idina also shared about how her partner's patience has played a role in their teamwork:

He now knows how to help soothe baby, he is very patient with him, like there's a time when he needs to be walked - being walked up and down steps is an instant soother for him...We always say we're in the ring and if baby is crying, I can just say I need to tap out and he'll say, okay, I'll take him and walk him and move him or whatever he needs at that time...We have to go at it with a team approach because if I lose having him on my team then having a baby is a lot harder than keeping him on my team.

Grace expressed gratitude of her partner's advocacy of breastfeeding when friends held divergent views. Grace noted how their personalities complement one another well and that this makes for effective co-parenting approaches. She noted later in her interview that when they do have different opinions, their ability to work through decisions has made them "closer as a couple":

He's never really been one for being involved in the night, but during the day, as soon as she would get done eating, he would go walk her up and down the hallway for as long as she would let him so I could try to nap.

Some mothers also expressed a perception that the transition to parenthood enhanced the closeness, and connectedness they have with their partner. This emerged for several reasons. The most common reason was that observing their partners become caring parents enhanced their respect for them. Mothers expressed gratitude for their partners' affection and care toward their babies and themselves. Francis shared examples of how she and her partner work as a co-parenting team:

I would say 9 out of 10 times he is the one saying, it will be okay, she's not going to cry forever, you've done everything you can. That's the most helpful - when he tells me, you changed her, you burped her, you fed her, at this point there's nothing else you can do, you've done everything you can, you're doing a great job. That kind of talking me off the ledge is a hundred percent what I need at that time...I've never felt such a need to be so supported.

Noelle shared:

We feel more connected than we ever have. I've always known he loved me...and then now being married and having a baby is definitely like, truly, this person is your family. I feel much more connected to him - our lives are completely intertwined.

Similarly, Idina addressed the awe she has experienced:

I can't imagine being with anybody else...I look at our son and what we did together and I'm like, this is so amazing we did this together.

Lee expressed how she feels an “extra connection” and is grateful and proud of her partner:

When we're out and public and we're working together so well and communicating, and he's helping out with things, I just feel like an extra connection. Feeling like, I'm really proud that he's the father of my son and that he's my husband. I'm really happy to be in the relationship I have...I'm a pretty religious person so I make my prayers every morning and I'm always so thankful thinking about how so many other fathers are so much worse than he is and he really does go out of his way to take care him.

Lee also spoke to the importance of having understanding of one another's views. She felt strongly that “strong communication,” “understanding each other's standpoint,” and considering “why they might be feeling the way they do” has heightened her compassion toward her partner when she feels frustrated.

Admiration of the partner as a parent. Half of the mothers directly expressed respecting or admiring how their partner had taken on the role of being a parent. Noelle stated:

It's really awesome to see him become a dad because he has gotten a lot softer - he'll give her kisses and tickle her and just play with her...he does a really wonderful job. When he's home he's receptive to her, he'll go up and change her diaper without me asking him. If she's fussy, he's very sweet, he will walk around with her and bounce her a little bit.

Grace commented:

It's made me feel a lot stronger about him, when I see them together - your heart kind of explodes (laugh) so I think it's definitely made me love him a lot more.

Lastly, Teresa shared:

There's a neat new connection of watching him be a dad, it's pretty cool.

Conflict

All of the mothers endorsed experiencing heightened conflict with their partners at some point since the birth of their child. Most participants mentioned an intentionality to address the conflict. For some participants, the conflict was a pattern and they made intentional efforts to confront and work through it. For example, Noelle shared about her tendency to bury negative emotions and that this strategy was no longer effective when she became a mother:

When she was first born and we were so exhausted and whatnot we had a few blowups and I just thought, well he just doesn't care, he's not paying attention and legitimately he just didn't know that I was having a hard time with it. So now I'll tell him and then it doesn't get to that point. Once I can get it out, we talk about it and we're able to move past it.

Teresa also spoke about her frustration of wanting her partner to be more involved with childcare responsibilities and how she was quicker to assimilate the parent role into her life:

There was an initial adjustment where we were both really confused and trying to get all these things worked out and get a routine established and kind of find ourselves as parents. And I got there faster than he did. I'm there and I'm comfortable, I feel like I've got this routine and I know what I'm doing, I know

how to make the house and our lives function again and I would say he is still catching up...And so in that regard there's been some tension recently - where I've adapted, I've changed, and I don't know if he's reluctant to, if he's just having a difficult time doing it or I'm not quite sure where he is on that.

Marie explained how she and her partner worked through her feelings of jealousy of the father-son relationship, as well as her frustration with her partner's participation in helping the family "get out the door":

For the first little bit, we were pretty pissy at each other, a little bit snippy...Just in the last few weeks, we have really had a good gel going where I haven't had to make requests and my husband hasn't had to argue for time with baby and it's just been a lot smoother now...Our arguments tend to be quite cyclical: 95% of arguments in our house is the misunderstanding of what the intent was behind what was said.

For other participants, the conflict was more related to acute stressors of parenthood, and adjusting to the various changes that occur after a baby is added to a family. Ann commented:

We have normal small disagreements, but sometimes things do build up and then maybe get expressed all at once where maybe they weren't as big of a deal but they were triggered by something else so it can be a bigger argument.

Idina explored how she and her partner have addressed challenging disagreements they have had since the birth of their son:

At first it was very stressful for a lot of reasons, I was emotional and protective, as a new mom I want him rocked a certain way or I want him swaddled him a certain

way and if you didn't do it right, I would pick at him - like do it different or do it my way...I kind of came to the realization of, okay, you can do it your way and I can do it my way and either way, the baby is still taken care of.

Frustration with partner response. In addition to the conflict addressed in the previous section, most mothers expressed frustration, dissatisfaction, and hurt about how their partner sometimes responded when they were experiencing challenging moments as new parents.

Noelle shared:

We're very different people, we've been together 10 years this year so we know each other very well and we've grown together a lot...I'm a lot softer, I'm a lot more emotional...I wish he was a little bit more receptive to that. He doesn't always know how to deal with that...he's more like a typical kind of masculinity kind of thing.

Teresa and Grace reflected on examples that left them feeling that their partner is not being an equal team member. Teresa noted:

He never says the word I'm "babysitting" the kid - it's your kid, you don't "babysit" your own child - but the feeling is still there. Him watching the child *for* me. "Can you watch her for me while I go do this?" Well no, you can watch your kid while I go do this...You always feel a little rushed trying to get home because he is watching the kid *for* you.

Grace explained:

He doesn't take care of her as much as I do and sometimes that frustrates me...Like me asking him to get something or to change a diaper and then him

saying no and me just not understanding why he's saying no or - that I even have to ask about it. A couple weeks ago I really wanted to take a bath. I just wanted 30 minutes to myself to just read, maybe. I asked him and he said no right away. I had to like convince him to go let me take a bath...I felt like he should have just said, yeah go ahead, I'll be fine, rather than me have to be like, please, come on, watch her so that I can take a bath.

Lee also shared frustration with her partner's choices:

I've wanted to see...more interaction with baby. He likes to play his video games or watch his shows and baby will be propped up, he will be trying to do both at the same time...It's things that I do myself too, just maybe not as much. It would be nice to see him down on the ground with tummy time more.

Intense Mood and Anxiety

Mothers spoke about experiencing a range of intense emotions throughout the transition to parenthood for a variety of reasons. In general, all mothers expressed enhanced awareness and range of their emotions. Two mothers stated awareness of the potential for postpartum depression. Ann shared about her previous experience of seasonal affective disorder and how that factored into perceptions of her mood during the transition to parenthood. Idina expressed her surprise at the intensity of emotions she experienced, as well as how her mother's postpartum depression with her first baby impacted her awareness of her strong emotions.

Experiencing heightened anxiety was also reported by two mothers. Noelle noted a history of panic attacks and experiencing feelings of "impending doom." She reported concerns that they might re-emerge with stressors and increased uncertainty. Teresa also

explained how her anxiety propels her to research, plan, and closely monitor her family's schedule in an effort to care for her daughter in a way she believes is most optimal based on her scientific research. In addition, she spoke about maintaining a set schedule so she and her partner are aware of the tasks that need to be accomplished. She expressed that motherhood has increased her anxiety, but that she has also had to become more flexible given the unpredictability of caring for a child.

Minimization of Distress

Throughout the interviews, regardless of the topic at hand, mothers commonly expressed the belief that what they were experiencing was not that difficult, even when sharing about challenges such as pain, fatigue, anxiety, and judgment. This minimization of distress was expressed in various ways such as incongruent laughter, downward comparisons, or making comments such as, "but it was okay, we got through it and it's better now."

Domain 3: Interaction of Breastfeeding and the Partner Relationship

The third primary domain of the interview explored the interaction of breastfeeding and the partner relationship. Mothers were asked open-ended questions about their perceptions of how breastfeeding, in particular, has impacted the partner relationship, as well as how the partner relationship has impacted their experiences of breastfeeding. Focused codes that emerged in this domain were: the impact of breastfeeding on physical intimacy, the impact of breastfeeding on emotional intimacy, partner emotional and practical support of breastfeeding, and partner's lack of support of breastfeeding.

Impact of Breastfeeding on Physical Intimacy

When mothers were asked about how they perceived breastfeeding to have impacted their relationships with their partner, all reported impact on desire, pleasure, and frequency of physical intimacy. In addition, all reported negative experiences at some point since the birth, with a range of perceptions on the severity of such impact. This section has several subcodes which reflects both the variations in responses, as well as the commonalities. Though the interview was geared toward eliciting responses related to breastfeeding, women initiated discussion about changes related to their physical shape as well of functions of their bodies.

Breast issues. Earlier, women's perceptions of breastfeeding was presented and most women mentioned temporary or ongoing discomfort or pain. In this section, women share how these experiences and other changes in their breasts impacted physical intimacy with their partners. Francis reflected on how breast pain affected her desire for physical touch during sexual activity:

Oh my god, even when we did resume things I told him, you cannot touch anywhere in this region, just because there was so much pain and half the time I was dealing with a mastitis infection or I had a blister on my nipple or something.

Noelle spoke about how her view of her breasts and their role in sexual activity has evolved:

Before you have kids your breasts are a sexual kind of thing - so I was kind of like oh how is that going to be, is it going to be weird for him or me. But really, we've gotten the flow of it and now it doesn't really seem like a weird thing. The only

thing – if my boobs leak on him or something during sex, that’s kind of an awkward thing.

Ann, Teresa, and Grace expressed feeling that their breasts no longer have sexual purpose. Ann shared:

It’s (breastfeeding) kind of changed the way I feel about my body, with breasts being sexual and stuff and not feeling that way anymore, they are just not for that purpose anymore.

Teresa shared:

They are not at all involved sexually, not touched, not acknowledged sexually. They were never a real sexual stimulus for me to begin with so there's not really any difference for me.

Grace and Marie also acknowledged the impact of leaking. Grace commented: You’re breastfeeding a lot, multiple times a day and they’re really tender and they hurt and you don’t feel like having them touched. And they'll leak randomly...So they’re more just for feeding now and you don’t really see them as a sexual thing anymore... Sometimes he'll want me to take my bra off which I can’t really do because I will leak everywhere and it just makes a mess.

Marie explained how once she no longer had to wear breast pads, her sexual activity has mostly returned to the way it was before her son was born:

For me having breast pads was just the grossest thing and when my husband would touch me, I told him - you need to give me a heads up...So it wasn't until my production slowed down a little bit that I felt a little bit more amorous...I'm a little bit sensitive about the idea of him having his mouth on my breasts, or

leaking and he has assured me that's never happened but that's the only hang-up when it comes to intimacy, I'm a little bit scared that I'm going to leak.

Fatigue and loss of ownership of body. Most participants reported the feeling that their bodies and breasts are over-worked. They expressed feeling tired and worn out as a result and that this impacts their desire for sexual activity. Some women also indicated feeling a loss of control over their bodies, as well as a loss of freedom of activities which led them to intentionally prioritize their bodies' needs and/or desires over that of their partners. Ann expressed:

I do feel weird sometimes if he touches me and it's like no, my boobs are touched all the time, they are exposed all the time...I'm not as comfortable necessarily and I don't feel like that is their purpose anymore, so it does create some physical boundary/barriers...In the beginning, partially because of pain and sensitivity, that would affect just touching, closeness, but now I'd say frequency or willingness on my part because I'm tired and my body has been used a lot. It kind of wants its space, so it has affected the desire to or the wanting to. I'm not used to my body being not just mine and I have less control over it. So then when I can have control over it, I do more often.

Idina shared similar sentiments about her desire and struggle to reclaim control over her body when she can:

When you're always giving up your body to somebody else, it's really hard to think sexually towards my husband, to give him anything because I'm always giving physically - my body - to another human being, and I just want time, just for me...I already feel exhausted, having to always constantly give up my body

and then I have this whole other being that has this sexual and emotional need from me. I feel like I can't ever win - each one needs me and I can't meet both.

Grace also acknowledged decreased sexual desire due to feeling fatigued and for other reasons:

I think it (breastfeeding) lowers my want of intimacy. I just never really want to, whether it's because I'm tired or I just don't feel like it in general, there's a lot more of me saying no, I don't feel like it. It happens quite often. When I put her to sleep, I usually want to go to sleep...or I want to do things for me like getting something to eat or taking a shower, going to the bathroom. I don't really feel like doing other stuff.

Hormonal changes. Women also alluded to or identified hormonal changes that impacted their desire for sex. Marie shared about the changes in her "drive":

Post-baby my drive kind of dropped...So for a while there, neither of us was really initiating. And both of us were kind of sad it wasn't being initiated but neither of us were doing anything...I don't know if it's like a hormonal thing. Idina echoed Marie's sentiments:

For me breastfeeding has really killed any sex drive that I had...like I could probably go the next year without having sex and I'd probably be okay. My midwife said that's part of what breastfeeding is, it's kind of a natural birth control, it can kill your sex drive, it can make you really dry, it can keep you from getting pregnant.

Teresa expressed an incongruence between her mental sex drive and her physical arousal:

The vagina is really dry which I know is a natural byproduct of breastfeeding. I would say mentally I can get in the mood, but physically my body isn't too able to get going. It doesn't really get wet or get excited at anything, even though mentally I can be like "oh yeah, I'm kind of turned on," so physical intimacy has definitely taken a plunge.

Time constraints. Some mothers noted that having limited time for sex decreased the frequency of sex. Ann shared:

It does kind of feel pressured sometimes - like we have to get it in now or it's going to be another five days or something.

Lee reported:

We have limited time until baby wakes up from a nap or until he starts crying or wakes up in the middle of the night or something... You get that rushed feeling because he's going to get upset soon... my mind is a little more distracted than his as far as that goes.

Marie reflected:

For a while there we had to be a lot more sneaky with being intimate. The times of the day that you can be intimate are very spelled out for you and it gets to be a little bit more predictable, like when you're going to make a move and how you're going to make a move which was boring for both of us.

Partner response and support. Women identified a range of partner responses in relation to the reduction and changes in sexual activity. These responses range from coping with humor, and responses that range from positive to mixed. A later section more fully addresses how partners verbally expressed their views their partners' bodies.

Responses using humor. Most mothers shared that laughing and joking was occasionally involved when partners communicated to one another about sex. For example, Francis shared:

That was hard for him to remember, like okay these (breasts) are off limits for a while...He was very understanding and we kind of joked about it.

Ann shared how her wishes to not have her breasts touched has been addressed: It's usually more of a joke than anything and not that big of a deal.

Noelle expressed how a light-hearted approach has been incorporated with acceptance:

When we are intimate I might spray a little bit because that's what happens. That was a little bit of a shock for him, okay yep that's happening, you deal with it. So that's been kind of a funny. (Before) I would be super embarrassed, like oh my gosh, that's terrible and he was good about being like, no, just laugh about it and move on. He realizes that it's a normal day to day thing, it's not a big deal to him.

Grace shared:

He always tries to go for 'em (laugh). And I have to be like oh no, stay away from them.

Positive responses. Mothers also expressed that their partners responded in positive and mixed ways to the changes in sexual activities. Some mothers readily shared how their partners were understanding of their decrease in sexual desire and activity. These women identified feeling appreciative and more comfortable due to this. Francis shared her perspective of how her husband has responded to changes in sexual activity in a supportive manner:

When it comes to intimacy and things like that, I don't even think about it (body changes), it doesn't bother me. My husband is very sweet about that and he makes me feel very beautiful. I know for him it (resuming sexual intercourse) seemed like a really long wait...He's been a lot more patient and understanding than I thought any man could be. He wanted me to enjoy the experience as well, and feel safe.

Similarly, Lee perceived her partner as being positive about changes in her body and accepting her decreased interest in sex:

He's always been so supportive and so welcoming of the changes even physically that I've had. There's things that I don't like so much about the changes of my body, like my stomach and things like that but he's always the first person to tell me how beautiful I am or how great I look or things like that. He's always been very supportive. He's certainly understanding - I will put forth an effort (to engage in sexual activity) and maybe this day didn't work so out - there's too much pain. And he'll be supportive if something hurts obviously, he doesn't continue with it either.

Mixed valence responses. In other circumstances, mothers viewed their partner's responses to changes in sexual activity to be mixed. In general, this looked like the partners expressing both an understanding as well as impatience and frustration:

Ann noted:

You can tell it's been hard. He's pretty understanding, but he would like things to be different.

Marie elaborated on her aversion to breast pads and her husband's reactions:

He was understanding - like he got it - he would just be like "oh, they're just your breasts" and I was like "yeah, but I don't feel sexy - yeah, I know you feel I'm sexy but I need to feel it", right? So the words were there but not necessarily the actions as far as him being understanding.

Grace expressed:

He's pretty good with understanding, sometimes though I think he does get frustrated. He thinks that it has to do with him where it really has nothing to do with him...I think he's been doing his best with not really having an understanding about it.

Similarly, Idina shared:

He's definitely been understanding. I know he expressed frustration, like can we like try to make a point of having sex more often? But he's never said it in a condescending way or a way that makes me feel guilty.

Noelle wishes that her husband was more aware of how she is feeling during intimacy:

Sometimes I wish he was just a little more aware...especially when we're intimate and I'm uncomfortable with something that we are doing...I wish that he was just a little bit more in tune with my emotional insecurities or my emotional needs related to those insecurities.

Partner's view of body. Women were asked to share how breastfeeding impacted their partners' views of their bodies and most provided examples of verbal reactions.

None of the partners indicated dissatisfaction, other than concerns related to sexual

activity, as noted above. Ann noted that despite her view that her breasts are no longer have a sexual purpose, her husband continues to view them as sexual.

Likewise, Lee shared:

Your milk coming in obviously makes changes to your body that are desirable for a guy. He's mentioned that a number of times - that he likes my new body.

Grace noted that her partner's approval of her body shape has helped her confidence. She shared:

He likes that I got bigger, you know the with the breast changes, they get bigger too and he likes that.

In contrast, Teresa's partner no longer views her breasts as sexual and she expressed gratitude of this:

He says that they belong to the baby for the time being...he mentioned, your boobs just look like elbows right now, they're just so not a sexual item which sounds kind of upsetting but it's really actually not - it's actually one of the nicest things. He liked them prior, he doesn't like them much now (laugh).

Openness. Most mothers spontaneously identified open communication with their partners related to changes in their bodies and sexual activity. Teresa noted:

I'm very open to saying, "hey, we haven't had sex in a while, what's up with that?" or I'll ask him, "do my boobs turn you on at all anymore?" or "is it weird that my nipples are huge?" questions like that, I throw them out there all the time. He's less likely to ask the questions but he always engages when I ask...He definitely knows my desire is lower right now.

Lee also shared about how she is open with her partner:

I'm open to telling him if or when or how or why I might be experiencing pain, we're rather open about things like that. We talk about how I would like to provide for him and be a good wife and take care of his needs and his desires and things like that, even if I might not be as interested.

Grace shared that although she is generally not confrontational, within her relationship she typically shares her feelings:

With him it's completely different, it's a lot easier to tell him what's going on and how I'm feeling.

Of all the mothers, Francis was the only one who reported complications with her recovery following birth. She delayed resuming sexual intercourse for several weeks beyond the standard 6 weeks of postpartum abstinence due to pain, as well as the recommendation of her physician. She spoke about how she and partner were open about where each was at throughout this process. She noted that she intentionally expressed how she was feeling to him so he was aware, as well as to reassure him of her plan to continue sexual activity when she was physically recovered.

Resolution. This section explores the two primary types of responses or strategies participants shared in managing concerns around sexual desire. A few participants mentioned that non-sexual physical affection matched the level of touch they desired. As well, a few participants spoke about their value of making a concerted effort to respond to their partners' sexual desires and needs.

Alternative affection. Lee provided examples of how she and her partner have compensated for the absence of sexual activity:

I'm still kind of healing, so that has certainly affected things. We've always snuggled, we hold hands. We still will put forth an effort to be close as often as we can.

Idina shared how physical closeness has enhanced emotional connectedness:

Sexually I know he tries a lot less, I think he can read like, okay, she seems tired, there's no point in trying. We'll be laying in bed, I'll be feeding baby and he'll be like, oh you look tired, do you want me to rub your back while you're nursing? Because we're always kind of close and snuggled up as a family, I think things like that have made him more aware of emotions that I'm dealing with.

Teresa shared that she and her partner are also physically affectionate:

He definitely holds hands, he usually will kiss me bye.

“Working on it.” It was important to Francis that her partner understood that her lack of sexual desire was a temporary circumstance:

I was like, I promise you - I promise, I really do want to have sex again - I'm not going to feel this way forever.

Lee and Idina noted a sense of duty to provide for their partners' sexual “needs.”

Lee shared in depth about this struggle:

I'm somebody that doesn't need sexual things as often as maybe the next woman, but he's a typical man, you know. So I want to be able to take care of my wifely duties and tending to his needs and his desires, while him understanding that I'm still healing so maybe something hurts, but there are alternatives to sex and things like that where I can still meet the needs that he has.

Idina also expressed her intention of “working on” her participation in sexual activity and identified feeling guilty:

I think it gives me a little bit of guilt because I’m like, oh I need to think of his needs more often, and I definitely know I’m lacking in that area right now...I know it’s a lot different than it was before we got pregnant. I guess I’m kind of working on it (laugh).

Marie also went through a process of making sexual activity more intentional and conducive to her life. She shared the outcome of a sleep consultant’s suggestions:

We have the evening for ourselves and so it's *so much better*...And it’s only recently that baby has his own bed that we can be a little bit more adventurous, a little more spontaneous, so that's starting to come back in the relationship just now...I’m making an effort, like I’ll initiate because I know that I should...If I participate in the initiation then it happens more often and we're both happier.

Impact of Breastfeeding on Emotional Intimacy

When asked in an open-ended manner how they perceived breastfeeding to impact their relationships with their partners, mothers generally replied with answers that initially referenced physical or sexual intimacy. When asked if there were other ways their relationship was impacted by breastfeeding, mothers shared about the following emotional and practical aspects. Some of these aspects overlap with responses that were shared earlier when mothers spoke about feeling closer to their partners as they observed and experienced the transition to parenthood together. Below are responses specific to perceptions related to breastfeeding.

Most mothers expressed that breastfeeding impacted emotional closeness within their partner relationships. Noelle and Grace emphasized that their partners' enthusiastic support and involvement with breastfeeding enhanced their feelings of emotional connectedness to them.

Teresa shared her perceptions of how breastfeeding has impacted her relationship: If anything it's been positive for me and him...He would probably say that it was positive, that he recognizes how much of a time commitment sacrifice it is for me...He's said it before several times, I'm putting in the most work right now and I think him knowing that and acknowledging that - it's been positive in that regard.

Ann and Francis provided examples of how their partner's involvement in their breastfeeding experiences enhanced closeness. Ann shared:

Especially early on when it was frequent...we were home together a lot so he would go get me things and make food so I felt really supported in that way. I felt like that brought us closer during that new parent time. I didn't feel isolated because I needed to be always breastfeeding, I felt like he was there and around, it was a nice way be in this situation.

Francis expressed:

It (breastfeeding) definitely strengthened the relationship. I think it's brought a new way of me loving him and him loving me because for me to see him take care of me that way and to care enough to help me through the painful times and to be my cheerleader and my coach and to push me to what I know I'm capable of or past what I thought I was capable of, like that's a new level of the love I

have for him. And I think it's the same for him seeing me do something that not every woman chooses to do ...He's told me that he is very proud of me for getting through the pain and doing that for our child - that means a lot to him. So I think he has a level of respect for me that he wouldn't have had before breastfeeding and the love that comes from that...I would think that he probably feels that it's brought us closer. It's definitely made him feel like more of a teammate. I carried the child and birthed the child and now I have to feed the child. I think it helps him feel more needed and involved...I think it helps him feel validated as a dad, that he's contributing something.

Idina shared how being more “exposed” has led to her feeling closer to her partner:

I'm definitely exposed a lot more than ever - I wouldn't normally sit in the living room with my breasts out...one of those things before that maybe would have felt awkward...So definitely, I think you're more close in that way.

Partner Emotional and Practical Support of Breastfeeding

Women were asked about their perceptions of how their partners were involved in breastfeeding. All women endorsed that their partners were supportive and most provided examples of both emotional and practical support. Further, the types of support indicated were common and significant enough to categorize the types into subcodes: the integral role of the partner, the shared decision, latent agreement, overt emotional support, overt practical support, mixed responses, and partners as advocates.

The integral role of the partner. Many mothers spoke to the integral role their partners played in their breastfeeding experience. They emphasized that their partners' involvement was vital for their breastfeeding success and continuation. Grace shared:

It's been better just because of how supportive he is. I believe if he wasn't supportive it would be a lot more difficult to just feel okay with breastfeeding. It's really helped - just having him there and knowing that he supports breastfeeding.

Lee expressed:

If your partner wasn't involved, wasn't pro-breastfeeding, I could see how that could be really tough to want to continue if there's all these issues kind of going on.

Idina noted:

I think if my partner hadn't been so supportive, it would have been a lot harder, especially those first few weeks. If your spouse isn't there - like on board, like okay, we're a team, we're going to get this done, I don't know how I could have made it through that period if he hadn't been like, we're going to get you what you need.

Francis also emphasized how crucial her partner's involvement was for her to continue breastfeeding:

I honestly think that she would not be breastfed to this day if he had not been so supportive.

Teresa expressed her need for support following the birth and how her partner met this need:

The amount of support I've gotten from him has really made up for the fact that I've had an unsupportive mother. A lot of people I've talked to leaned really heavily on their moms...I didn't have that so having a husband that's been as supportive as him has made this work. Those first 10 days - I was coming off of a c-section so I was still pretty sore and really tired. I had to get up and pump and I had to also try and then feed her along with that. I honestly don't know if I could have handled it in those first 10 days by myself. If he hadn't been as in tune as he was, I think it probably would have fallen apart, I think we would have ended up on formula, just out of sheer exhaustion.

The shared decision: “Always in the plan”. Participants shared about their partners' involvement with the decision to breastfeed. As mentioned previously, most women made the decision easily and quickly, with many women perceiving it as the default or even only option of feeding their baby. Further, as will be explored in this section, women reported that their partners were immediately and completely on board with this decision. This foreshadows the theme of most partners being in total agreement and in support of the mothers in various aspects related to breastfeeding.

For example, Ann shared that her partner had been exposed to breastfeeding through family, and he expected that she would breastfeed “the way God intended.” Likewise, Marie's partner also had sisters who breastfed and noted: “he just assumed I would breastfeed.”

Similarly, Noelle commented:

I think because his mom breastfed we'd always talked about it - like it was never really questioned - we were both on the same page with that.

Lee elaborated on her partner's involvement in the decision:

He's always been very supportive of it and very encouraging of it. Like me, it's just never been a question of what I'm going to do for feeding, for the same reasons - the benefits of it... We never really had a discussion because it was always in both of our minds a for sure thing - that we were going to do everything it takes to give him breast milk.

Idina shared:

I'm lucky that I have my husband – he is always very supportive of breastfeeding. I don't even know why because his mom wasn't a big breastfeeder, he just never had an issue with it. It was like, if that's what you want to do, that's what we'll do.

Grace explained how her partner was easily convinced when she informed him of the health benefits:

I gave him a list of the benefits of it and it was a pretty quick decision... he was pretty pro-breastfeeding once he read those.

Francis shared:

We took a breastfeeding class at the hospital - I'm so glad we took that because I learned a lot, more than I thought we would and my husband learned a ton. I knew that I would want him to be supportive of me breastfeeding... He thought, wow this is the greatest thing ever... we're going to do this, we're going to be champions at this. That was really important - that got me through it and kept me on track to make it happen.

Mothers described specific ways in which their partners demonstrated support throughout their breastfeeding experiences. These actions can be categorized as the following: latent agreement with being on the same page, overt emotional support, overt practical support, and mixed valence responses.

Covert emotional support: being on the “same page”. This code pertains to latent examples of breastfeeding support that most women addressed and women perceived as being helpful. Examples of this include unspoken acceptance and listening. For example, Ann shared:

I definitely had some moments, and he always listened when I would talk about what my current frustration was or what I was worried about, or wondering about, he was definitely there for that...Being able to be very open in our home, even like not ever having to worry about covering up, being very comfortable with my body with him has made it much easier too.

Noelle echoed how her partner’s non-judgment has been helpful:

He's pretty easy going, with how I could see myself keeping the morning feeding going (beyond 12 months) for a little more bonding and he's okay with that, he doesn't think it's weird.

Grace spoke about the importance of having shared parenting views:

If your partner doesn't have the same views as you it could definitely get a little muddy and get more difficult. If you have a supportive partner it really means everything when you're trying to breastfeed.

Noelle also spoke to the importance of having similar views toward breastfeeding:

We've just always been on the same page with that completely.

Overt emotional support. Most women readily described examples of how their partners provided hands-on, active support. These answers were coded into two categories: overt emotional support (e.g., positive comments, encouragement) and overt practical support (e.g., bringing water, helping with the latch). However, women frequently expressed that practical support provided enhanced their mood and positive perceptions of their partners, thus these codes and experiences are strongly linked.

Ann shared an example of when she felt supported by her partner:

We went to a wedding the first night we left baby and I pumped in the car and he came out to the car with me. He's done a pretty good job - because it shouldn't be an isolating thing, it is just me but it's not just my child.

Francis shared how her husband's support of her breastfeeding is a new experience within their partnership:

I was raised in a generation where it was like, anything you can do I can do better and this is the only circumstance in our relationship so far where he literally can't feed the baby for me...So having that new aspect of the relationship, that new level of love in our relationship and knowing that trust, that he has my back no matter what.

Teresa shared how her partner voices his appreciation:

He definitely thanks me for doing things, I have to get up to pump a couple times a night still. He always thanks me for that.

Overt practical support. Most women shared how helpful their partners were with asking for how they could help, bringing them water and the baby, and putting the

baby down after feeding. Noelle shared how her partner provided instrumental support while they initially learned about breastfeeding:

When we were in the NICU and the lactation specialist would be in there, he would be right there...he would ask questions. He would relay information to me after, like...remember how she said you just have to relax, try to have the nipple this way or...he was really paying attention to the little things. It was definitely a group effort between the two of us...I had to get up every 2 hours and he would get up with me. And I would tell him, no go to sleep and he would still be like no I'm going to come with you. He was just right there wanting to be a part of it.

Idina also shared an example of hands-on support from her partner:

He was never afraid to be hands on. The lactation consultant had showed him a way that he can help with pushing on a clogged duct when the baby is nursing and he was always willing to do that...He was always like, I'll take him and I'll burp him and lay him down. If he hadn't been willing to do that and I had to do all of those things on my own, even little things like get up and get water, I think it would have been a lot more different because it is really draining...If he knows I'm going to be home from work in half an hour, he'll do a really good job of trying to make the pacifier last that half an hour because he knows that I don't want to pump if I don't have to.

Francis' partner checked in often with what she needed:

He was extremely supportive and just always like, how can I help you?...He would help me do things like keep track of how long ago I fed her, do you need

more water, do you need a snack, do you want me to go bring her to you, are you comfortable, do you need another pillow, that teammate kind of feeling.

Similarly, Teresa's partner was "eager" to jump in:

This is his area to shine. He's been super involved, super eager to help where he can, everything from grabbing the nursing pillow and bringing her to the bed. For a while she tried to roll her bottom lip so she wasn't latching that well and he would roll her lip out back out, got up for all the feedings, he's been great.

Lee explained how he her partner has been helpful when she breastfeeds in public:

He will hold him and try and keep him calm while I get everything situated or he'll help me set up, like maybe he'll rearrange the apron so I'm least exposed.

Ann shared:

He definitely helped get things for me, made a lot of meals and things like that, filled up my water because every time I sat down, of course, it would be empty.

(With breastfeeding in public) he usually has tried to make sure I have a cover or he helps me get it situated or adjusted if I need to.

Francis shared how her partner's encouragement and acceptance was what she needed when breastfeeding was especially difficult:

It was hard for him to see that it hurt me so badly and to know that there was nothing he could do. He told me...it's your decision, but I know that you can do this. That was a big big help for me...He said, I hate seeing you go through this pain and I'm not going to be disappointed at all if you want to stop...but if you want to keep going, I'm here for you, and that was huge.

The partner as an advocate. A few fathers also demonstrated their support by verbally advocating for breastfeeding. Grace shared several examples of how her partner advocated for breastfeeding. She spoke about how he came to her defense when her friends made comments about breastfeeding being “gross” and that she should leave the room to feed her daughter in their bathroom:

He was really supportive about that, he told them that you guys don't eat in the bathroom, why does she have to?...He thinks I should be able to feed her whenever and I shouldn't have to use a cover and people shouldn't think it's weird because it's natural. The same friends tried getting me to use formula at night because they said it would help her sleep longer and he knew that I didn't want to give her formula at all so he just told them not to bring it up and we were just going to breastfeed and formula was not an option for us. And then somebody gave us a can of formula and he gave it right back (laugh).

Grace also shared how her partner was an advocate for her following the birth: My boyfriend actually convinced me to try it (breastfeeding) without the nipple cover when we were still in the hospital so then I got a lactation consultant to help get it back to not using the cover like we had originally been doing when she was first born. I'm glad he talked me into doing that because it would have been a lot more difficult to have to have a nipple cover on and to try to feed her.

Teresa's partner has also been verbally supportive of her breastfeeding:

I will hear him on the phone with his mom and he'll say, yeah, Teresa's breastfeeding the baby because blah blah blah (sharing examples of benefits of

breastfeeding). He can roll with that, it's pretty cool to see him involved with that. I might have created a lactivist accidentally (laugh).

Partner's Lack of Support of Breastfeeding

Earlier, mothers' perceptions of experiences during which they were dissatisfied with their partner's involvement during the transition to parenthood was explored. This section specifically pertains to incidents when women perceived their partners to be unsupportive, or less supportive than they desired. All mothers could identify such incidents and expressed varying degrees of dissatisfaction ranging from mild annoyance to outright frustration. These experiences ranged from mild dissatisfaction to more heightened frustration with partners' responses. Grace shared how her partner is sometimes not perceptive of her feelings about socializing with friends who have made anti-breastfeeding comments:

I don't feel like going anywhere sometimes...I just want to hang out with him and not have to rush out of the room and leave the conversation (to feed baby)...Sometimes he can get annoyed and sometimes he tries to talk me into it which is understandable, but for the most part if I'm not feeling it, he understands and he makes excuses (to the friends) for why we don't want to go out or whatever...He still just thinks I should just feed her in front of them so I guess he just doesn't understand that I get uncomfortable in front of them...Sometimes he doesn't pick up the cues - if I'm feeling isolated or if I feel ready to leave their (friends') house and she's getting fussy and hungry and I don't feel like feeding in the bathroom...But then I just have to speak up and say it's time to go home and he says it's okay.

Teresa shared about how she and her partner have clashed over the stored milk supply:

I'm very protective of that frozen milk - maybe a little neurotically protective. There were a few times where he made a bottle with breast milk when she was crying at night and his logic was I don't want you to have to wake up...It is well-meaning on his end, it was just a difference in what he thought was important versus what I thought was important. He thought I needed to sleep and I thought we needed to save that milk for the apocalypse, or whatever I'm saving it for, I don't know.

Lee and her partner have also had differing views on the nighttime feeding routine:

We've certainly had our bumps. Mainly it's if my partner is really tired...and he'll kind of fight his duties and beg me to go out of my schedule to do it. But for the most part he's been really cooperative and really helpful...There have been times where I am just too exhausted, please just thaw milk and feed him yourself. And he will do that. He understands that there are some times that I'm just hitting my breaking point and I just need that break.

Ann has struggled for much of her breastfeeding journey with physical discomfort and her son's poor latch. She noted perceived latent pressure from her partner to continue breastfeeding, primarily for economic purposes:

He is pretty supportive if I tell him what I want to do, but...I think that he kind of has the idea of "if you can do it, why not keep doing it." I don't doubt that he

would be supportive of me but I do kind of get that feeling of why not though, is that a good enough reason or can you (laugh) try something else.

Ann also shared about how her partner has noted that she cannot be as involved with activities outside the home due to breastfeeding:

It's just easier for me to stay at home and he still wants to go out and do things and I'm usually pretty okay with that, but sometimes I'm like hey I want you to spend time with me too, so then he'll be like, "You can't do that because you're breastfeeding." You can tell that barrier has been challenging or it's just not as easy. We did go out with some friends one weekend for one day and I brought baby with, but I didn't get to participate as much as I wanted to.

Francis shared about how her partner wanted her to stop breastfeeding when it caused her injury and pain:

Once when she had injured me on both sides and he saw it and he was like, we're done, you can't keep doing this. Those first few months it kept getting reinjured, so many times. At one point I was bleeding and he was like, I cannot let you do this, you need to be done... I remember crying because it was just so painful and knowing that I was just going to have to do it again and he was like, I can't watch you do this again.

Marie noted her reactions to comments her partner has made about breastfeeding:

The only times I got upset were when I was pumping and hearing comments...like, are you milking a cow? I think every new dad makes some stupid comment like that. You know, you're vulnerable, there's post baby weight and your boob's hanging out, and it's not sexy...having a suction tube hanging on

your boob and then clinging to a bottle, like, it's not nice... We had a serious discussion of why...emotionally it is a sensitive thing and why my body has changed and now be sensitive to that and that was the end of it.

Similar to the experience Teresa shared of her partner's struggles to wake up to care for their daughter, Lee's morning schedule is also rigidly timed. She shared an example of a frustrating conflict:

We had one rough night...Baby was stirring and he didn't want to get up... He asked if I would be willing to nurse instead of him feeding a bottle...I told him I didn't have enough time and so he put baby in the crib and said you're fine...basically refusing to take the time with baby...In that aspect he's still a little selfish... That was our biggest fight. And the outcome - I ended up nursing him... We went over it afterward and talked it out and it hasn't happened since.

Idina shared about frustrations related to feeling exhausted in evenings:

My husband would come home from work and say "oh my god I'm so tired I need to get some sleep I'm so exhausted." And I would just look at him, like, are you joking?...I just remember being so frustrated. A lot of that is probably because I wasn't getting good sleep. Now, usually he will kind of grumble...but then he'll get up and do it.

Summary of Results

Eight first-time, partnered, breastfeeding mothers between 3 and 8 months postpartum participated in this study. They engaged in semi-structured interviews regarding perceptions of their breastfeeding experiences, the transition to parenthood, relationship satisfaction and functioning, and how their partner relationship and

breastfeeding interacts. Through CGT, focused codes were uncovered that highlighted frequent and impactful themes. These codes were grouped into three broad categories: breastfeeding experiences, the transition to parenthood, and the interaction of breastfeeding and the partner relationship. The next phase of data analysis, axial coding, allowed for integration of these themes to produce a model for how the partner relationship interacts with first-time mothers' breastfeeding experiences. This model will be addressed at the outset of the Discussion chapter. Following this, the results and the proposed model are compared and contrasted to existing literature in the breastfeeding, parenting, and romantic relationship fields.

CHAPTER V

DISCUSSION

The purpose of this study was to explore primiparous mothers' perceptions of the interaction between their partner relationship and breastfeeding. Participants were interviewed at 3 to 8 months postpartum about the transition to parenthood, including their views on partner relationship functioning, satisfaction, quality, and closeness. In addition, participants were asked to share how their relationship has impacted their experiences with breastfeeding and their perception of the involvement and support of their partner. Lastly, participants were asked about how breastfeeding has impacted their partner relationship functioning and satisfaction. Due to the lack of prior research specific to the interaction between breastfeeding and partner relationship factors, Constructivist Grounded Theory (CGT; Charmaz, 2014) was selected as a means to create a model based on the lived experiences of participants in the current study.

Using CGT allows for creation of an “abstract theoretical understanding of a studied experience” (Charmaz, 2014, p. 4). Charmaz (2014) purports that GT does not seek to generalize or explain, but to interpret to the specific experiences and voices of participants, while also acknowledging the experiences and bias of the researchers. Per CGT, I considered that multiple realities exist within a context of power, privilege, and oppression. I strived to “show connections between micro and macro levels of analysis and thus link the subjective and the social” (Charmaz, 2014, p. 241). Therefore, this

model is most applicable to first-time mothers in committed, long-term, highly satisfied, heterosexual relationships, who are of moderate socioeconomic status and who were determined to successfully breastfeed prior to the birth.

The focused codes uncovered through data analysis were reviewed and categorized through axial coding (Charmaz, 2014) and a model of how partner involvement interacts with breastfeeding was developed, Alignment and Attunement: How the Partner Relationship Facilitates Breastfeeding and Family Cohesion. This model includes eight recursive processes: (a) getting on board: the decision to breastfeed, (b) holding on tight: perseverance through struggles, (c) focusing on the baby and teamwork, (d) role shuffling, (e) settling into the routine and roles, (f) nurturing the partner relationship, (g) feeling grounded, and (h) being present and responsive across systems.

Alignment and Attunement: How the Partner Relationship Facilitates Breastfeeding and Family Cohesion

Mothers shared a wide array of experiences related to breastfeeding, their experiences of becoming parents, changes in their partner relationship and intimacy, and the role of the partner in breastfeeding. As expected based on past literature, the partner alliance played a key role in breastfeeding experiences, particularly at crucial points during the initiation and continuation of breastfeeding. The partner relationship also impacted family functioning. The significant themes that emerged have been integrated into a model is applicable to all of the participants in the study. The model is comprised of components that were described by the mothers. Though the components can be experienced in phases, the model is not meant to be a chronological depiction of the interaction between breastfeeding and the partner relationship and the different

components are experienced in different ways across couples. For example, multiple components can be experienced at once, and members of the couple may not experience the same processes simultaneously. However, the model is presented in an order that is generally reflective of the majority of the participants' experiences.

Getting on board: The decision to breastfeed. Most mothers had decided to breastfeed prior to the birth with little deliberation. Two primary reasons were noted for this. The first is that breastfeeding was perceived as the default method of breastfeeding. Though in general breastfeeding was perceived as being under-represented in society and peer groups, most participants knew of family members who had breastfed or were currently breastfeeding. The second primary reason that women decided to breastfeed was due to the knowledge of the health benefits of breastfeeding. In addition to these reasons, and perhaps due to these reasons, women identified a belief that they would be successful in implementing their plan to breastfeed. Women also reported that all partners immediately agreed with and enthusiastically supported their decision to breastfeed.

Regardless of alternate resources of support and employment status, partner support was identified as being important to participants. Early in the breastfeeding journey, this support was demonstrated through physical presence, verbal encouragement, and emotional support. From the moment the baby arrived, the partner was involved, often with eagerness, consistency, and affection toward baby and mother. The partner offered instrumental support with little prompting by bringing the mother water, food, nursing pillow, the baby, and asking how they could help her to be more comfortable. Some partners were also involved in reminding mothers what lactation consultants suggest. The partner was willing to meet the mother where they were at, which required

compromising sleep duration and quality, as well as the freedom they once knew. The partner empathized with the mother's struggles of physical pain, recovery from labor and delivery, and breastfeeding challenges. Though unable to directly feed the baby, he attempts to compensate by nurturing the mother and baby through other means. At a time of heightened vulnerability, pressure, and uncertainty, the partner plays an integral role in the initial phases of breastfeeding. In turn, the mother feels grateful and supported, and confident that she can continue breastfeeding.

Holding on tight: Perseverance through struggles. Couples in long-term, committed, and highly satisfactory relationships enter the transition to parenthood and breastfeeding with significant advantages. They are typically experienced in working with one another and have already grown and solidified as a dyad over time. This connectedness buffers the couple's struggles in the next phase of establishing breastfeeding. This first month in the postpartum period is a turning point where exclusive breastfeeding rates sharply decline. The couple continues to be a cohesive team as they work to overcome the many obstacles inherent in the process of breastfeeding such as latch difficulty, nipple pain, and uncertainty about milk supply. The primary focus is still on the baby and maintaining breastfeeding. Some acceptance occurs at this point for mothers who may be struggling with barriers that cannot be mitigated solely by their persistence. However, most of these barriers can be diminished with the appropriate support, knowledge, resources, and treatment. Partners who are able attend to mothers' various needs enhance the mothers' growing self-efficacy and determination as challenges arise and dissipate. Mothers increasingly take ownership of their identity as

breastfeeding mothers. They become empowered and emerge as advocates for self and baby as they face and overcome difficult circumstances.

Simultaneously, mothers may experience a sense of obligation to continue breastfeeding. This perceived obligation is typically identified as a personal or family value; however, it is also unconsciously or consciously driven by latent and explicit cultural influences. Mothers often experience guilt when feeding difficulties arise and the belief that their bodies are flawed if they are not able to exclusively breastfeed. They feel tremendous pressure as they perceive themselves as the sole providers of nourishment for their baby. Heightening this perception of aloneness, the breastfeeding mother may be relegated to the sidelines and feel isolated as she is removed from the systems she was once a part of. This often arises due to practical limitations, such as the desire or need to be physically available to feed the baby frequently throughout the day and night. The feelings of isolation also emerge from the internal emotional conflict of the desire to prioritize caring for the baby, while also holding a desire for self-care and autonomy.

Though partners are very much involved in this stage of breastfeeding complications, mothers often feel that the responsibility to successfully breastfeed is ultimately on them. They vacillate between a sense of pride and purpose, and fear of failure and shame. Their determination to breastfeed seems to grow simultaneously with emerging uncertainties. Often at this time mothers are confronting challenges with the transition to parenthood such as intrapersonal and interpersonal role negotiation with their partners and fatigue. As they work through the many changes, their purpose and identity as parents typically continues to grow. Concurrently, the teamwork between partners becomes more integrated into their day-to-day lives.

Focusing on the baby and teamwork. As new parents face obstacles and overcome them, they are simultaneously becoming a more cohesive and complementary team. As mothers settle into establishing breastfeeding they tend to feel more stable and competent. Partners continue to be attentive and may expand their caregiving responsibilities as some mothers return to work outside the home. This requires fathers' involvement at a more concrete level. Examples include tasks such as feeding the baby breast milk from a bottle and increased participation in housework and childcare. Increasingly, parenting tends to become second nature and less conflictual: the relationship with the baby is now the focus, rather than the struggle to keep up with parenting demands. The baby is now a familiar being that parents care for in a more equitable and collaborative manner. Often mothers are surprised at how much work this journey is, and upon reflection feel pride in themselves and their partners for being able to succeed. The guilt and doubt that was once so prominent is largely replaced by acceptance and compassion for self and one another.

A primary avenue through which this teamwork occurs is through intentional and focused communication. Mothers are likely to identify issues as they arise and initiate dialogue with their partners. Parents prioritize arriving at resolutions and may disregard their own preferences or self-care in order to care for the baby. Couples use their existing communication skills, strengths, and familiarity and commitment to one another as tools, while integrating new skills required for their new roles as parents. They grow in their ability to complement one another; they discover that their diverse ways of conceptualizing and approaching problems enhances their strength as a parenting unit. Mothers in relationships that intentionally prioritize direct communication feel

emotionally closer to their partners: they feel heard, valued, and validated in their roles as partner and mother. Through working closely together to achieve significant goals, they each have a deeper awareness of one another. Mothers often express experiencing a new dimension of love and closeness with their partners. They become more grounded in their co-parenting role and feel more whole, rather than isolated and restricted.

Role shuffling. Simultaneously, as couples become a more cohesive parenting and partnered unit, they are also engaging in an overhaul of their identities and roles. The strength of a couples' relationship and buffers this storm. The challenge most prevalent in this component is achievement of perceived balance. As they navigate parenting, breastfeeding, and relationship tasks, mothers increasingly realize that attention in one direction detracts from another. For example, the time and energy invested in coordinating schedules takes away from time and energy available to focus on the partner relationship quality. Therefore, while there is a joining in the mission of co-parenting, the maintenance of the relationship itself remains peripheral. However, parents who are like-minded in this quest and hold shared goals are more frequently able to provide the patience and support their partners need and the quality of the relationship is sustained.

Role shuffling is constant throughout the transition to parenthood, however it is most prevalent during this time. As parents settle into their parenting roles, there is now a recognition that other aspects of life must be more fully addressed and reintegrated. These areas include the many systems the couple are a part of. Uri Bronfenbrenner's (1986) ecological systems model is particularly applicable at this stage. Breastfeeding spans various systems: intrapersonal, the immediate family, extended family, work,

community, and culture. As such, women may feel clashes amongst systems. A common example is incongruence of motherhood and career roles.

Though attending to one system may compromise the quality or effectiveness of another system, parents who are attentive to the partner relationship are best able to work toward optimally balancing demands. For example, when a mother returns to work, the partner may need to be responsive by feeding the baby stored milk if the baby wakes early. While this will detract from the father's quality of sleep, it will allow for the mother's quality of sleep to be enhanced. While role shuffling is the predominant task, stable couples are skillful in being receptive, engaged and considering one another's systems when making decisions throughout the day. Role clashes frequently occur with attempts to address, integrate, and support one another's self-care and needs. As noted within the perseverance component of the model, sustaining breastfeeding requires persistence in the face of such conflicts. In the role shuffling component, there is a recognition that this conflict remains, and an acceptance of the need to sacrifice one domain for the betterment of another. Examples of how this might occur is when a mother declines plans with friends in order to spend time with her baby, or a mother taking her baby on a trip and not being able to participate in activities that are not baby-friendly.

Transformation of the woman's body. Another primary aspect of role shuffling is the change in how women perceive their bodies, and how their bodies are perceived by others. These changes become in the partner relationship. Women often feel self-conscious, desexualized, embarrassed, and ashamed about their postpartum and lactating bodies. Simultaneously, women feel a sense of power, responsibility, and purpose. This

vacillation between self-consciousness, acceptance, and celebration of their bodies continues throughout the breastfeeding journey. For example, women may feel that breastfeeding is weak and passive as it removes them from their systems in which they were active and strong; however, they may also feel empowered and in tune with their bodies. As a participant expressed, this view can waver: “Some days are harder than others.”

Another shift in how women perceive their bodies is in regards to their new purpose and role. Whereas in the past, most couples viewed women’s breasts as having a sexual purpose, they are now viewed as having a nonsexual purpose of feeding a baby. Some women can feel burdened and averse to the mere thought of engaging in sexual activity. While women are generally initially accommodating of this change, partners typically experience a range of responses including: a neutral response, continuing to view breasts as sexual, and/or viewing breasts as non-sexual. Partners generally express support and admiration of the changes a woman’s body goes through during the postpartum phases. Often women feel a sense of powerful purpose; that they are using their bodies as they are intended to be used, rather than how society has dictated the female body. Thus, women simultaneously experience an increase in control over their bodies, while also relinquishing control as their bodies are constantly in demand by frequently feeding babies.

Settling into the routine and roles. The role shuffling component can gradually transition into a phase where both parents embrace and are more comfortable in their role as parents. This may happen earlier for women, and some women perceive this as being more instinctual and innate than it is for their male partners. Mothers often expressed that

initially, they perceive themselves to be more equipped to be responsive to the baby's needs, and to be more skillful in parenting. This may be related to the physical preparation inherent in pregnancy, as well through intentional research and resource-gathering. At this time there is often an acceptance that change is constant. There is realization that challenges arise and they can be overcome due to enhanced self-efficacy. In addition, parents recognize that parenting issues are often temporary as babies pass through stages and as parents' routines change. There is a comfortable familiarity and stability of the present circumstances and the focus can now shift to reintegration of the partner relationship.

Nurturing the partner relationship. As the parenting role becomes familiar, partners are now more motivated to expend energy on returning to and nurturing the relationship and one another. Though there typically continues to be diminished sexual desire for women, they are becoming more attuned to the emotional and physical aspects of their relationship once again. This is due to many reasons such as the desire to serve their own needs and wants, the desire to accommodate their partner's needs and wants, the desire to return to pre-baby routines, or a combination of reasons. For example, although sexual intercourse may still be medically contraindicated or undesired by the woman due to pain, lack of sexual arousal, or fatigue, physical intimacy re-emerges as a relationship priority. Concurrently, men often demonstrate a willingness to be patient, compassionate, and to prioritize the comfort and care of their partners. They are typically willing to set aside their preferences in order to support their partners, though they may feel frustrated and lack understanding.

The acceptance displayed by partners buffers women from feeling the shame they may otherwise experience. Women are socialized to view their bodies as primarily sexual and that their value is dependent on their appearance and how they can serve males. The postpartum period challenges these views on various levels and women may feel self-conscious, guilty, and confused. However, support within the partner relationship provides a corrective emotional experience; the message from the partner can undermine the message from a patriarchal society. In such cases, women feel further validated for breastfeeding, despite the stigma they may indirectly or directly experience. This bolsters the trust and closeness they feel in their relationship and the emotional health of the family is strengthened.

Feeling grounded. The last component is a culmination of the previous components. Often at several months postpartum, mothers find their ease with breastfeeding and parenting. At this point, mothers typically perceive breastfeeding to be more efficient, comfortable, predictable, and integrated into their lives. Couples continue to feel closer to one another as partners. The co-parenting role is now a familiar dimension of the relationship that neither dominates nor detracts from the dyad relationship.

Being present and responsive across systems. This factor is integrated with the previously note six components. Throughout the breastfeeding journey, partners' ability to be present and responsive has significant bearing on how mothers perceive the partner relationship quality and satisfaction. Further, this engagement is crucial for the partners to perceive their role in the breastfeeding relationship as valued and integral. The more

present and responsive partners are to one another, the more they feel appreciated and validated. Ideally, the support within the partner relationship is reciprocal.

Thus, breastfeeding enhances emotional closeness in a stable and close relationship through the following processes. Consistent emotional support of a partner throughout the postpartum period enhances the likelihood that breastfeeding will be successfully initiated. With continued support and engagement, breastfeeding becomes established and is assimilated into the relationship and as part of the family routine. This contributes to the mother feeling fulfilled and balanced, and thus able to increase her investment in recouping the quality and emotional closeness of the partner relationship.

The next section of the chapter will address a second literature review and compare and contrast the current study's findings and model with related literature.

Second Literature Review

Consistent with Grounded Theory, the initial literature review provided an overview of the studied constructs to establish context of the studied phenomena, rather than to impose a specific direction or theory on the current participants' experiences. This method follows Strauss and Corbin's (1998) suggestion that researchers avoid becoming submerged in previous research before data collection. Charmaz (2006, 2014) offers the rationale that this prevents predetermined notions from rigidly influencing data collection and analysis, and encourages development of themes based directly on the participants' words and experiences. As such, the Discussion chapter provides a second literature review to compare and contrast previous research with the current study findings. In doing so, aspects of the literature that aligned or did not align with the suggested model are highlighted and explained. These comparisons are noted in rough chronological

fashion for the sake of organization, however the reader is reminded of the non-linear, recursive components of the model. Implications of the study are then explored with a specific focus on suggestions for clinical and educational interventions and future research. Lastly, a discussion of the limitations of the study are provided. The chapter starts with a literature review related to the first component in the model, Getting on Board: The Decision to Breastfeed.

Getting on Board: The Decision to Breastfeed

Every first-time parent must initially make the decision of how they feed their child, though they may not be able to ultimately control the outcome. However, for many participants in the current study, breastfeeding was not perceived as a choice, but an expectation that was determined before the birth of the child. Parents noted several reasons for this, including exposure to breastfeeding in their own family, knowledge of the benefits of breastfeeding, and supportive partner attitudes of breastfeeding. Responses related to the decision to breastfeed were coded into categories labeled *The Decision*, *Expectations*, and *Cultural Influences*.

Family Influences on Breastfeeding

Indeed, as the current study replicates, previous research has demonstrated that mothers who decide to breastfeed often have families who support breastfeeding. Codes that related to this component include *Outside Support* and *Cultural Influences*. Williams, Innis, Vogel, & Stephen (1999) investigated influences on the decision to breastfeed or formula feed and found that mothers who breastfeed are more likely to regard family advice, friends, and other mothers' advice as influencing their decision to breastfeed as opposed to mothers who used formula.

Partner Attitudes toward Breastfeeding

Along with family attitudes toward breastfeeding, partner attitudes were also identified as significant factors in the decision to breastfeed. Responses that related to partner attitudes toward breastfeeding in the initial stages were coded *The Shared Decision* and *The Integral Role of the Partner*. Interviews with mothers in prior research demonstrates that partner attitudes toward breastfeeding impacts the decision to breastfeed and this finding was also well represented in the current study. For example, Arora, McJunkin, Wehrer, & Kuhn (2000) investigated differences in feeding decisions between breastfeeding and formula feeding families. For women who used formula, the most common reason reported was the mother's perception of the father's attitude toward feeding. In addition, the women in Arora et al.'s (2000) study reported that they would have been more encouraged to breastfeed if they had access to more information from prenatal classes and media, as well as more family support.

More recently, fathers' involvement in breastfeeding is being more closely examined by researchers. A study by Mitchell-Box et al. (2013) demonstrated that fathers' positive attitudes toward breastfeeding were significantly related to breastfeeding initiation and continuity. Mothers accessing WIC services and their partners' infant feeding attitudes were measured by the Iowa Infant Feeding Attitude Scale (IIFAS; de la Mora, Russell, Dungy, Losch, & Dusdieker, 1999). Similar to the current study in which participants reported immediate and constant support of their decision to breastfeed, Mitchell-Box and colleagues (2013) found that mothers' and partners' attitudes toward breastfeeding was significantly correlated with their intentions to breastfeed. However, it is unknown if and how the views of mothers impacted the fathers views and vice versa.

Scott, Shaker, and Reid (2014) examined how parental attitudes of breastfeeding early in pregnancy impact how infants are fed upon hospital discharge. They also utilized the IIFAS (de la Mora et al., 1999) with both members of the couple at the 8-12 week mark of pregnancy. Results revealed that at discharge, about half of the women were exclusively breastfeeding while half were exclusively formula-feeding. As with the Mitchell-Box et al. (2013) study, partners' scores correlated with one another significantly, however maternal, but not paternal attitudes significantly predicted feeding decisions. Also similar to Mitchell-Box and colleagues' (2013) research, this study suggests that early intervention with both members of the couple may serve to impact couples' attitude and intentions toward breastfeeding.

Holding on Tight: Perseverance through Struggles

Although most of the women in the current study made the decision to breastfeed with ease, almost all had difficulty with initiation of breastfeeding. Common challenges reported included establishing a good latch, milk supply uncertainty, nipple pain, and fatigue. Barriers related to health such included an infant with jaundice and recovery from the birth for mother or child. Despite these difficulties, the women in this particular study persisted and were able to continue and eventually establish stable breastfeeding. The components of the model—both facilitative and impeding—that are related to this persistence are described below. However, prior to addressing these different components, it seems beneficial to highlight one particular finding within the overall literature—specifically—the relationship between attachment style and breastfeeding.

In the initial literature review for this paper, it was noted that women with “attachment approach orientations were more likely to breastfeed, breastfeed longer, and

continue breastfeeding when they experienced initial difficulties” (Scharfe, 2012, p. 218). Bartholemew and Horowitz (1991) suggest that adult attachment is how one views their own worthiness of love and support from others and levels of related confidence or anxiety related to this. Attachment also relates to how one views whether or not others should be approached or avoided in times of stress. According to Bartholemew and Horowitz (1991), an individual with an attachment approach orientation feels worthy of receiving love and in times of stress approaches others.

Overall, the women in the current study demonstrated attachment approach orientations in how they described their relationships with their partners. They identified feeling receptive to and desiring of their partners’ love and approached them by asking for help and being in their company. For example, one mother described how she felt validated when she expressed her feelings and needs to her partner as they navigated breastfeeding and co-parenting roles. Another mother was grateful for the care her partner took to encourage her when she had difficulty establishing a good latch and had fears about sufficient milk supply. In general, the mothers expressed a value for openness of their emotions and needs to their partners, even in times of duress and vulnerability.

Parenting Self-efficacy

Women in the current study frequently addressed how the challenges of their new roles as parents impacted their partner relationships. They also frequently addressed their perception of parenting skills and self-confidence. Mothers’ responses that relate to parent self-efficacy include *Coordinating a New Routine*, *Positive Experiences*, “*Finding the Extra Love and Energy*”, *Striving for Balance*, and *Figuring it Out*.

Self-efficacy is defined as “an individual’s conviction that he or she can successfully perform certain tasks or behaviors in a given situation” (Dennis & Faux, 1999, p. 400). Several transition to parenthood models demonstrate the development of parenting self-efficacy. For example, Schoppe-Sullivan, Settle, Lee, and Kamp Dush (2016) looked at how self-efficacy is connected to supportive co-parenting, parenting stress, and satisfaction. Their findings suggest that the level of co-parenting supportiveness perceived by fathers at 3 months postpartum is related to lower attachment anxiety during the third trimester and lower parenting stress and higher parenting satisfaction at 9 months postpartum. In addition, for mothers who reported low parenting self-efficacy, perceived level of co-parenting support was inversely related to parenting stress, suggesting that having a supportive co-parent can decrease parenting stress, regardless of parenting self-efficacy. Interestingly, for fathers who reported high parenting self-efficacy, perceptions of supportive co-parenting were positively related to parenting satisfaction. Taken together, these results suggest that the co-parenting alliance particularly benefits mothers’ parenting stress when they have low parenting self-efficacy, and benefits fathers’ parenting satisfaction when they have high parenting self-efficacy.

An earlier study by Hudson, Elek, and Fleck (2000) also investigated parenting self-efficacy and parenting satisfaction in first time parents at 8, 12, and 16 weeks postpartum. Both mothers and fathers reported linearly increasing parenting self-efficacy for the first 3 months postpartum. In addition, both mothers and fathers also reported that their parenting satisfaction also increased over this time. Results showed that at each point of data collection, fathers rated their infant care self-efficacy as lower than mothers.

For mothers, infant care self-efficacy was related to parenting satisfaction at each time point, while for fathers, it was only related at the 12 and 16 week marks. As with the Schoppe-Sullivan et al. (2016) study, Hudson et al.'s (2000) research further demonstrates the need to assess parents' perceptions of self-efficacy in order to provide targeted and evidence-based interventions that can enhance self-efficacy and parenting and co-parenting satisfaction.

Breastfeeding Self-efficacy

In addition to parenting self-efficacy, mothers in the study also identified aspects of self-efficacy related to breastfeeding as they reflected on their experiences. The codes that are related this are *Initial Experiences*, *Struggles*, *Perseverance*, and *Commitment to Continuing*. Research by Dennis and Faux (1999) and follow-up studies have consistently demonstrated that self-efficacy is a key determinant of whether or not women initiate and continue breastfeeding. Indeed, all participants in the current study expressed a high level of self-efficacy when they discussed their commitment to breastfeeding amidst struggles. Though they also identified uncertainty and frustration, there was a strong desire to persist and a prevailing belief that their bodies would cooperate with this goal. This mindset was present at both the initiation and continuation phases of breastfeeding.

Research indicates that enhancing BSE is crucial for breastfeeding rates. Lack of confidence in breastfeeding is a commonly reported reason that women cease breastfeeding earlier than planned (e.g., Blyth et al., 2002, 2004; Turner & Papinczak, 2000). To more closely examine maternal confidence factors, Dennis and Faux (1999) constructed the Breastfeeding Self-Efficacy Scale based on Bandura's (1977) self-

efficacy theory. The scale demonstrated predictive validity and BSE scores were positively related to breastfeeding at 6 weeks postpartum.

Dennis and Faux (1999) explain that breastfeeding self-efficacy (BSE) is “based on whether [a mother] has breastfed an infant previously, observed successful breastfeeding by others, and received encouragement from significant others to breastfeed” (p. 400). In addition, physiological and psychological factors such as fatigue, pain, and anxiety are factors that contribute to a mother’s belief of whether or not she can breastfeed. Research reviewed by IBCLC and writer Nancy Mohrbacher (2012) indicates that BSE impacts various processes involved in breastfeeding and most mothers in the current study identified such processes. They include: the decision to breastfeed, the effort toward breastfeeding, using encouraging self-talk, and breastfeeding perseverance. Mohrbacher (2012) notes that low BSE is related to having doubts that breastfeeding will work, less time applied to learning about breastfeeding, doubts related to milk supply, and early supplementation due to these doubts.

Mohrbacher (2012) purports that BSE is not a static trait and that it vacillates depending on experiences and responses to such experiences. This also aligns with the reports of mothers in the current study, particularly when they recalled challenges that sparked uncertainty. Mohrbacher (2012) suggests that there are four avenues to increasing BSE as based on Bandura’s (1977) model of self-efficacy. The first is to master the task of breastfeeding, which can be facilitated by emphasizing small successful steps. Indeed, the women in the current study addressed how they felt energized when accomplishing tasks such as overcoming a poor and painful latch, or when they saw that their baby had gained weight. A second avenue is to be exposed to

others' successful breastfeeding, such as friends, or through peer-to-peer breastfeeding support groups. A third pathway to increasing BSE is receiving positive support and praise from others and reducing exposure to criticism and discouraging others. A fourth strategy to enhance BSE is to improve a mother's physical and psychological well-being as mothers who are rested, comfortable, and happy are more likely to be confident that they can breastfeed versus mothers who are fatigued and distressed.

Vulnerability

The transition to parenthood is a time in which various stressors emerge. Indeed, many participants expressed various challenges when asked the question, "how has being a new parent been for you?" In addition to reflections related to self-efficacy, mothers also reported feeling vulnerable when sharing about their experiences. Codes related to this include *Intense Mood and Anxiety* and *Minimization of Distress*. Indeed, participants endorsed that parenting and breastfeeding elicit feelings of vulnerability such as perceived lack of competence and uncertainty and confusion about how to resolve problems. The Vulnerability-Stress-Adaptation (VSA) model (Karney & Bradbury, 1995) conceptualizes how partners accommodate stressful events and has been applied to transition of parenthood research (Trillingsgaard, Sommer, Lasgaard, & Elklit, 2014). The VSA model suggests that relationship outcome is dependent on the following factors (selected current study findings pertaining to the model are in parentheses following their related factor): (a) individual vulnerability (such as the need to frequently be physically exposed while breastfeeding, and changes in body, breast function, and shape impacting identity), (b) contextual stress (such as the transition to parenthood and breastfeeding

challenges), and (c) adaptive couple processes (such as establishing a new routine and managing childcare as co-parents) (Karney & Bradbury, 1995).

In reviewing the VSA model, Trillingsgaard et al. (2014) notes that a valuable contribution of it has made is that unlike other close relationship models, it considers that the “interaction of risk factors from different domains (individual, contextual and couple level) creates the circumstances of relationship distress during early family life” (p. 509). Indeed, the current study demonstrates that the outcome of the relationship of the couples was strong, stable, and emotionally attuned. This seemed to be largely due to the couples addressing the problems within each domain as a team and not dismissing their importance. However, a critique of the VSA model in the transition to parenthood context is noted by Kluwer (2010) who argues that parenthood itself is not necessarily a stressor. In addition, the VSA model does not consider the strengths and resources of couples and that along with other transition to parenthood theory, it is often anchored in a deficit approach and ignores gender differences.

Focusing on the Baby and Teamwork

The third component in the model is focusing on the baby and teamwork. Mothers in the current study made it apparent that their partners were directly involved in caring for their infants. They reflected on how the couple typically operated as a team to approach and overcome challenges and to establish co-parenting as a priority. The responses relevant to this domain were coded as *The Integral Role of the Partner*, *Intentional Communication*, *Teamwork*, *Conflict*, *Latent Agreement*, and *The Partner as an Advocate*.

The Role of the Partner

The transition to parenthood literature offers insight on the impact of co-parenting on the partner relationship. The care of the child is a major aspect of this transition that requires great attention and responsibility. Fillo and Simpson (2015) use attachment theory to offer an explanation of how partners perceive their relationship and the division of childcare. They studied parents every 6 months starting at around 6 weeks before the birth and through 2 years postpartum. They found that women and men who have less of an avoidant attachment orientation manage childcare tasks better than men who have an avoidant attachment orientation. This aligns with the current study in which women felt that they took on the role of being a parent more readily and easily than their partners. Though attachment orientation was not directly measured, it could be gleaned given the descriptions of their long term, committed, and stable relationships. Further, none of the women reported consistently avoidant or ambivalent behaviors from self or partner.

Another example of a transition to parenthood theory is Doherty, Kouneski, and Erickson's (1998) Responsible Fathering model. This was developed with the aim of creating "research, program development, and public policy" (p. 285) that targets fathers. This model modifies Bronfenbrenner's (1986) ecological systems model and suggests that there are five primary factors that influence fathering: child, mother, father, co-parental relationship, and contextual factors. Their model proposes that the three individual factors (child, mother, father) exist in the within the system of the co-parental relationship and contextual factors. The parenting alliance and the context thus impact the quality of each of the dyadic and triadic relationships, as well as relationships outside of the triad. In addition, Doherty et al. (1998) purport that the duration and quality of time

that fathers spend with children are positively related to romantic relationship satisfaction. Mothers in the current study reported experiences that indicated that their partners were highly involved in co-parenting. If the mother was not available for parenting duties due to work or focusing on other tasks such as breastfeeding or resting, the father was almost always identified as the co-caregiver. In addition, though mothers were by far the primary providers of breast milk and this meant spending large amounts of time in direct physical contact with the baby, several mothers spoke of how their partners would attempt to compensate by engaging in alternate tasks with the baby such as bath time, burping, or rocking and walking the baby to sleep.

Though the focus on the baby that breastfeeding requires was generally regarded as necessary and positive, it did not come without costs. Mothers in the current study expressed feeling fatigued, uncomfortable and constrained. Some acknowledged feeling envious of their partners who had more freedom to leave the house and engage in activities including work and social events. However, often when such feelings were expressed, women had a tendency to minimize or dismiss their validity. This may be due to several reasons: coping strategy, expectations based on culture, family, and self, and identification with the role of sole nourisher. Minimization of distress may have served to help mothers cope in order to focus on their many tasks at hand. The demands of new motherhood may pressure mothers to negate or suppress difficult emotions so that they can charge ahead. Expectations based on culture, family, and self may dictate a mother's belief that she should withstand struggles in order for the benefit of her infant. This rugged individualism and bootstrap mentality is present in general Western culture, and particularly in the Midwest (Vandello, Hettinger, & Michniewicz, 2014) where half of

the participants resided. Lastly, some women strongly identified with their role as being the sole nourisher for their baby and that this responsibility and role supersedes their pain and discomfort. However, despite the purpose that minimization of distress can potentially serve, it seems that for mothers in this study, expressing their emotions to their partners proved to be a more beneficial strategy. Mothers spoke about how doing so led to practical changes, such as a freeing shift in the delegation of responsibilities. Expressing emotions also contributed to enhanced emotional closeness, such as in the case of several participants who expressed feeling closer to their partner when they felt they were on their team.

Role Shuffling

Several mothers described feeling pulled in different directions due to the shuffling of various roles and obligations in the family and outside the home. The responsiveness of their partners was a factor in how mothers perceived their circumstances and the degree of role strain they experienced. The participants in the study emphasized that their partners' support enabled them to feel validated as they navigated these challenges.

Transformation of the Woman's Body

An element of role strain that was particularly present were the emerging roles of "breastfeeder" and "mother" which at times conflicted with existing roles of "sexual being" and "partner." These experiences were explored in responses coded *Breastfeeding in Public*, *Body Image*, *The Impact of Breastfeeding on Physical Intimacy*, *Fatigue and Loss of Ownership of Body*, and *Partner's View of Body*. As the role of their body shifted from sexual to functional, each woman eventually considered how to re-incorporate the

sexual role of their body into their identity. One area that was impacted by this change for all women was with body image. Women described feeling a range of perceptions that fluctuated between aversion, acceptance, and appreciation of their bodies.

How a woman perceives her body has implications on her well-being. When asked to share their views on the changes in their bodies, the women in the current study reported various mood-related factors such as irritability, fatigue, and occasional anxiety and sadness. Previous research identifies depression as a factor related to body image in the postpartum period. For example, Silviera, Ertel, Dole, and Chasan-Taber (2015) reviewed literature related to body image and perinatal depression in an attempt to investigate links. Across 19 studies, several important findings were highlighted. Perhaps the finding with the greatest implication is that body image has been consistently demonstrated to be inversely related to prenatal and postpartum depression, regardless of the time periods studied.

In addition to impacting postpartum mood, body image also appears to impact breastfeeding. Since Silviera et al.'s (2015) meta-analysis, Zanardo et al. (2016) studied links between body image, postpartum depressive symptoms, and breastfeeding. Mothers completed surveys on body image perception and postpartum depressive symptoms and were interviewed about breastfeeding at one month postpartum. Zanardo and colleagues (2016) found that postpartum depression symptoms were related to poor body image. In addition, mothers who reported depressive symptoms were more likely to not be exclusively breastfeeding as compared to mothers who did not report depressive symptoms. These findings were consistently demonstrated through the 6 month postpartum mark. This study suggests the importance of normalizing body changes.

Incorporating such messages in prenatal classes and medical appointments could potentially bolster the chances of successful breastfeeding and deterrence of postpartum depression symptoms.

Settling into the Routine and Roles

Mothers in the current study were interviewed between 3 to 8 months postpartum and all spoke about having established a sense of routine, though acknowledged that this was an ongoing challenge due to ongoing changes. The routines they identified related to various domains of their lives including co-parenting, childcare, and work and household tasks. Codes that were developed based on responses related to these aspects of breastfeeding and parenting include *“Everything got Better and Easier,”* *“Breastfeeding Changes how your Body gets to Interact with the World,”* and *Work: Issues with Accommodations and Identity.*

Longitudinal research in the parenting literature addresses the development of the co-parenting relationship and related variables. Bouchard (2014) investigated the parenting alliance and measured attachment orientation and relationships satisfaction. Her findings indicate that new parents with insecure attachments orientations as measured before the birth have “lower levels of alliance with their co-parents 6 months after the birth” (p. 25). Consistent with Feinberg’s (2003) findings, the quality of the co-parenting relationship is significantly related to the overall relationship between partners.

In addition, Bouchard’s (2014) results also suggest that men who report insecure attachment are more likely to perceive a decline in their relationship quality after becoming fathers. Similarly, women who report insecure attachment are also more likely to perceive a decline in their relationship quality after becoming mothers. Further, they

also perceive their parenting alliance to be weaker than that of women who report secure attachment. Bouchard (2014) suggests that men's parenting alliance perceptions are less affected because women experience more role strain and decreased autonomy after becoming parents as compared to fathers. These findings appear to align with mothers' perceptions in the current study. Most of the participants described the ability to more quickly adjust to the parenting role than their partners. In addition, the women perceived their parenting alliance to be strong, as demonstrated by how they described the teamwork involved in co-parenting and working through the transition to parenthood changes, as well as how they described their relationship satisfaction and quality. Most of the mothers in the current study also spoke about feeling stable in their current circumstances, despite the persistence of parenting challenges. In general, these challenges were perceived as normal (e.g., fatigue, breastfeeding difficulties, adjustments in identity and body function).

Changes in employment outside the home and housework were roles and routines that were also explored in the current study. Both women who returned to work outside the home, as well as women who did not, expressed feeling generally satisfied and grateful for their employment status. Regarding work in the home, two of the three stay-at-home mothers spoke to wishing their partners were more involved, but felt that they should take on most of the housework for the practical reason of being more available to do it. Research by Katz-Wise, Priess, and Hyde (2010) examined gender differences and division of household labor during the transition to parenthood. They collected questionnaire data from women four times between 5 months into their pregnancies up to 1 year postpartum. Aligned with Bouchard's (2014) claim that women's roles change

more than men's when becoming parents, Katz-Wise et al. (2010) found that women's gender-role attitudes and behavior changed more than men's and became more traditional, though men also reported becoming more traditional in their attitudes and behavior. The researchers this suggests this is due to mothers being more involved in baby care, such as breastfeeding, and gaining reinforcement from society's views on what constitutes motherhood competency. They argue that men's traditional views may become more salient as the financial responsibilities of raising a child emerge and the identity of being a provider becomes more prominent.

Yavorsky, Kamp Dush, and Schoppe-Sullivan (2015) also examined gender roles. Using a longitudinal design, they investigated the division of labor within dual-income couples across the transition to parenthood. Their findings demonstrated that mothers were the primary caregivers and that their hours work outside the home stayed constant. Researchers also found that after becoming parents, women worked an additional 2 hours a day while men worked an additional 40 minutes per day within the home. These findings are also in alignment with the current study in which some women perceived that they undertake the majority of childcare responsibilities. It is difficult to know if this is due to their breastfeeding role being a time-consuming task. However, regardless of how this additional time is spent, addressing this aspect of the transition to parenthood in prenatal settings would likely benefit parents for several reasons. Sharing this information could serve to normalize the change in roles in responsibilities and allow space for parents to explore how they can maximize their limited time, be aware of potential inequity, and support one another.

Nurturing the Partner Relationship and Feeling Grounded

The last two components of the model highlight that nurturing the partner relationship reconnects and grounds the couple as stable unit. As parents turn more toward one another, they integrate their parenting roles which serves to strengthen the partner bond, rather than to distract or detract from it. Though there does not appear to be research that specifically targets this phase in the transition to parenthood literature, there are studies that address the life satisfaction of couples who are further along in the transition to parenthood and breastfeeding trajectory. These studies target role balancing. Codes that relate to these components of the model include *Impact of Breastfeeding on*

Emotional Intimacy and Resolution

For example, Sumra and Schillaci (2015) conducted a study to investigate inconsistent findings in the literature of whether or not women who hold multiple roles experience more or less stress as compared to women who hold fewer roles. Researchers measured women's involvement in various roles along with perceived stress and life satisfaction. Findings suggest a positive relationship between level of role engagement and life satisfaction, and no impact of role engagement on perceived stress. In the current study, participants reflected on their level of satisfaction with their numerous roles. An area of significance for most women was the importance of resuming their sexual role within their relationship. In addition, some women also spoke about prioritizing and reclaiming their identity and interests, such as involvement in physical activity. In the Sumra and Schillaci (2015) study, variables such as frequency of sex and exercise were predictive of higher role satisfaction and lower perceived stress. Lastly, another finding

that relates to the current study is the notion of the “superwoman,” defined as women who are highly engaged in the partner, mother, worker, and homemaker roles.

Contrary to expectations, Sumra and Schillaci’s (2015) results revealed that superwomen do not have higher levels of perceived stress compared to other women who have less role engagement. In the current study, though levels of stress were not directly inquired about, it did not appear as if the mothers who had returned to work outside the home experienced more stress. However the mothers that worked outside the home addressed fatigue and sleep challenges more frequently than their stay-at-home counterparts. In addition, all of the women who had returned to work outside the home expressed dedication to their jobs and did not indicate resentment. In relation to the partner and mother roles, all women in the study expressed commitment and involvement with their infants and partners suggesting high engagement in these roles. Lastly, a few women expressed holding a value of having an orderly home and were highly engaged in their homemaker role.

Another study that examined postpartum partner intimacy (Ahlborg, Dahlöf, & Hallberg, 2005) found that at 6 months postpartum, Swedish primiparous couples were generally happy in their relationships but unhappy with the sexual relationship. The most commonly stated problem for both members of the couple was “being too tired for sexual activity” (p. 167), though it was especially prevalent for women. The implications of this study are important as they address how couples can respond to such discontent. The researchers found that rather than compensate for sexual activity through physical affection, strong communication predicted higher levels of relationship satisfaction. However, the study also found that fathers had higher desire for physical affection. This

speaks to the need to both normalize sexual concerns with postpartum couples as well as to emphasize communication as way to maintain and improve relationship satisfaction.

The authors also note that communication between partners about desire, intention, and impact of physical touch could alleviate confusion, discomfort, and shame around expectations of the outcome of sexual activity. They share the example of a woman lacking sexual desire and not showing physical affection toward her partner for fear of being misunderstood in her intentions. Communication about such circumstances could clarify each other's perceptions and promote non-sexual touch which is both typically desired and beneficial for both parents (Ahlborg et al., 2005).

Also in relation to emotional and sexual intimacy, the current study demonstrated that women's perceptions of how breastfeeding impacted emotional intimacy was not as salient as how it impacted sexual intimacy with their partner. When women were asked about how breastfeeding impacted the partner relationship, they generally alluded to changes in their sexual functioning. This may be due to a two reasons. First, it is possible that the long term nature of the couples' relationship buffered any impact of breastfeeding on emotional intimacy, whereas the physical changes in the perinatal and postpartum periods impact sexual functioning regardless of the stability of the partner relationship. Second, emotional intimacy may be more difficult to operationalize, assess, and quantify (e.g., some may view it as being present in ongoing interactions with their partner, while some may view it as intentional and overt expressions of affection that diverge from day to day communication). On the other hand, sexual intimacy may be more readily accessible for participants to reflect on due to its more active and specific nature.

This last component of the current study's exploratory model also pertains to how women perceive breastfeeding. At the time of their interviews, mothers perceived the transition to parenthood and breastfeeding to have become familiar, routine, and less time-consuming. In addition, most mothers expressed that breastfeeding was enjoyable, and that they appreciated the connectedness with their infants as well as knowing that they were providing them with beneficial nourishment. Though there is not extensive of research on the psychological or emotional benefits of breastfeeding for mothers, a few researchers have sought to learn about such processes related to breastfeeding.

For example, Kendall-Tackett (2015) has examined breastfeeding and postpartum depression as well as other psychosocial aspects of breastfeeding. Her research was initially prompted by the once-followed notion that if a woman experiences postpartum depression, she should supplement with formula in order to be able to rest or sleep more. However, recent research indicates that breastfeeding mothers actually sleep more, have better physical health, more energy, and are less likely to experience postpartum depression than formula-feeding or mixed-feeding mothers (Kendall-Tackett, Cong, & Hale, 2011). Kendall-Tackett (2015) suggests that breastfeeding may buffer women from experiencing postpartum depression, or be a coping mechanism as it provides women a sense of purpose and connectedness. In addition, she purports that "breastfeeding has a protective effect on maternal mental health because it attenuates stress and modulates the inflammatory response" (Kendall-Tackett, 2007, p. 1).

Further, more recent research (Kendall-Tackett, Cong, & Hale, 2013) indicates that exclusive breastfeeding even decreases the negative impact of previous sexual assault. Though a history of sexual assault predicts decreased quality of sleep and

increased risk of depression, these effects were less severe for exclusively breastfeeding mothers as compared to mixed- and formula-feeding mothers. In addition, exclusively breastfeeding mothers had lower levels of anger and irritability compared to other mothers. Groer and Kendall-Tackett (2011) suggest that this is related to the physiological mechanisms of breastfeeding and how they buffer the stress response. A study by Groer, Jevitt, Sahebzamani, Beckstead, and Keefe (2013) supports the notion that this may be due in part to the release of oxytocin that occurs during milk let-down. They write that animal studies have demonstrated that oxytocin triggers a protective antistress response that decreases the reactivity of cardiovascular and neuroendocrine systems that are activated in high stress situations. In addition, research with breastfeeding mothers has shown that during active breastfeeding, mothers display reduced autonomic activity which is also linked to the stress response (Light et al., 2000). Further research will hopefully be able to assess for more long term effects of stress reactivity in breastfeeding and non-breastfeeding mothers.

Earlier research on how breastfeeding impacts mood and identity was conducted by Schmied and Barclay (1999). They studied women's experiences of breastfeeding through semi-structured interviews. Results showed that women identified breastfeeding as being central to their motherhood role and that most of the women were committed to breastfeeding. A third of the sample expressed that breastfeeding fostered predominantly positive experience, including feelings of connection, harmony, and pleasure. Forty percent of participants reported mixed and neutral experiences. The remaining 25% of women described predominantly negative breastfeeding perceptions and experiences. For the women who had positive perceptions of breastfeeding, many of the themes uncovered

in the current study were reported: celebrating and feeling proud of their bodies for its ability to nourish the baby, embracing the challenges and tasks of motherhood, and putting the baby's needs above the needs of themselves and others.

Being Present and Responsive Across Systems

This component is integrated within the previous seven areas. Partners' presence and responsiveness across systems impact their perceptions of relationship satisfaction and functioning. This reciprocity influences how appreciated and validated couples feel during the transition to parenthood as they navigate various domains in their lives. Research by Cowan and Cowan (2000) addresses systemic influences on couples within the context of the transition to parenthood.

Cultural Context

Consideration of the ecological context is consistent with the current study which demonstrates that the transition to parenthood and breastfeeding experiences are embedded within multiple systems. Whereas once these processes may have been regarded as private and personal, the impact of other individuals (e.g., extended family), agencies (e.g., workplace policies, hospital resources), and culture (e.g., sexualized view of breasts) pervades these domains. Bronfenbrenner's (1979, 1986) ecological systems model has been widely applied to child development research, and is also relevant to partner relationship development. Bronfenbrenner (1986) notes that mothers who perceive their partners to be supportive are more likely to feel satisfied in their partner and parenting relationships.

Cowan and Cowan's (2000) adaptation of the ecological systems model (Bronfenbrenner, 1979, 1986) captures how satisfied couples navigate and are influenced

by various domains. Successful couples are able to manage the multiple systems in order to be overcome the stressors of the transition to parenthood and to emerge as an even stronger partnership. According to Cowan and Cowan (2000), the five domains of family life are: (a) changes in identity and inner life, (b) shifts in the roles and relationships within the marriage, (c) shifts in the three-generational roles and relationships, (d) changing roles and relationships outside the family, and (e) new parenting roles and relationships. Cowan and Cowan (2000) suggest that most couples face these changes in the transition to parenthood. They also believe that the transition to parenthood is a more challenging experience for present-day couples as compared to previous generations due to the following: more choices about when and if to marry and when or if to reproduce, isolation and living apart from family of origin, expansion of women's roles, and lack of family-friendly social policies. Each of these issues was identified as being present in the lives of many of the couples in the current study.

Several other researchers have addressed the later postpartum stage as it relates to partner relationship satisfaction. Chong and Mickelson (2016) studied new parents at the 9 month postpartum mark and found that mothers who perceived the division of household and childcare tasks to be fair were more likely to be satisfied in their relationships and to feel emotionally supported. Shapiro et al.'s (2000) research mentioned in Chapter Two is especially consistent with the current study findings. The participants in the current study were in committed, stable, and close relationships. Shapiro et al.'s (2000) study demonstrated that relationship satisfaction was significantly correlated with fathers' expression of fondness and high attentiveness to the relationship.

Indeed, the perceptions of most of the mothers of the current study reflects that these behaviors were explicitly and frequently present and in their relationships.

The Theory of Planned Behavior, the Partner Alliance, and Breastfeeding

In reviewing the literature, an existing model, the Theory of Planned Behavior (Ajzen, 1991) emerged as having relevance with the current study's findings. Along with construction of a new model based on participant's experiences, CGT also supports the use of integration of existing theory to aid in explaining phenomena (Charmaz, 2014). The current study's Alignment and Attunement model describes how breastfeeding and the partner relationship interact as perceived by first-time mothers who are in committed, long term, and stable relationships and who are persistent in breastfeeding. An integration of this model with a previously validated theory can help to further illustrate how partner alliance factors impact breastfeeding outcomes. The Theory of Planned Behavior (TPB; Ajzen, 1991, 2002, 2011) extends the current study's Alignment and Attunement model to demonstrate how the partner alliance, along with *Attitudes*, *Subjective Norms*, and *Perceived Behavioral Control* contribute to breastfeeding decisions and persistence. In the following section, italics are used to highlight the TPB's components and the reader is encouraged to see Figure 1.0 for a diagram of the integration of TPB and the Alignment and Attunement model.

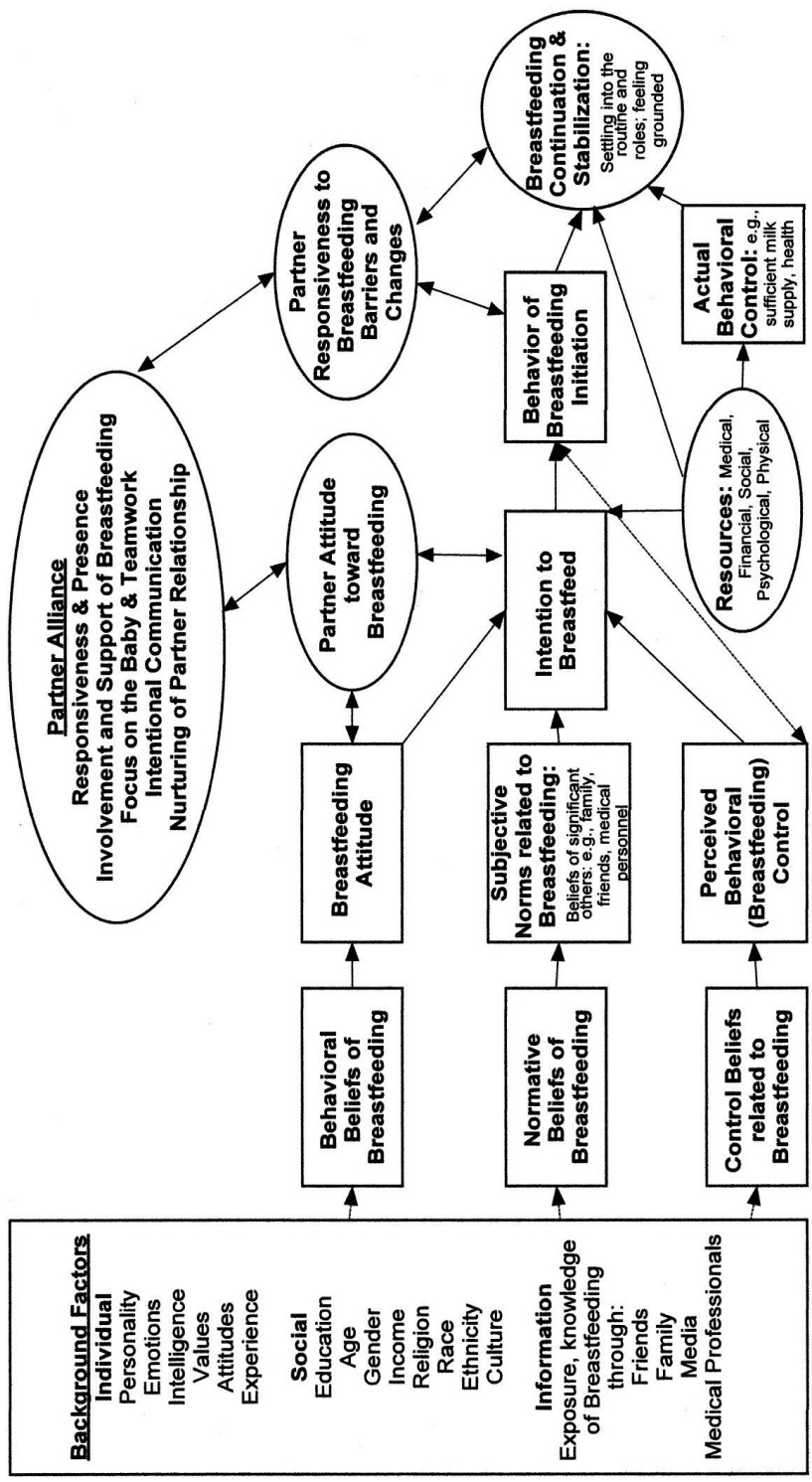


Figure 1. "Partner Alignment and Attunement and the Theory of Planned Behavior".

The Theory of Planned Behavior

According to the TPB (Ajzen, 1991) an individual's *Intention* to conduct a behavior is the primary cause of that behavior. *Intention* is developed by way of one's *Attitudes*, *Subjective Norms*, and *Perceived Behavioral Control*. Ajzen (1991) defines *Attitudes* as the individual's evaluation of carrying out the behavior. *Subjective Norms* are the social pressures individuals perceive that either encourage or discourage pursuit of the behavior. *Perceived Behavioral Control* is the individual's perception of the level of difficulty of performing the behavior. The TPB thus purports that an individual will perform a behavior if they have intention, opportunities and resources, and that an intention is formed when an individual deems the behavior to be positive, perceives that others deem it important for them to perform it, and has perceived control.

TPB has been frequently applied to explain the process of engagement in health behaviors, including breastfeeding. For the purposes of both elaborating on the TPB constructs, as well as to illustrate how the theory complements the current study's model, the behavior of breastfeeding will be discussed in relation to TPB constructs. In their research with breastfeeding outcomes and TPB, Swanson and Power (2005) state that women experience a vast array of influences in their decision to breastfeed. Women are not only impacted by their "own underlying attitudes, skills, abilities and beliefs," but also by "social, cultural, economic and psychological factors" (p. 273).

The TPB consists of *Background Factors*, *Behavioral Beliefs*, *Subjective Norms*, and *Perceived Behavioral Control* (Ajzen, 2011). Figure 1.0 presents the Partner Alignment and Attunement model integrated with the Theory of Planned Behavior (PAATPB). The rectangles denote components of the original TPB model (Ajzen, 2011)

integrated with breastfeeding as the *Planned Behavior*, while the ovals denote components added from the current study findings.

Background Factors are a list of individual and social variables, along with informational resources that are noted to impact individuals' beliefs. These include "factors of a personal nature such as personality and broad life values; demographic variables such as education, age, gender and income; and exposure to media and other sources of information" (Ajzen, 2011, p. 1123). Background factors that current study participants implicitly or explicitly indicated as impacting their breastfeeding intentions and beliefs include previous exposure to breastfeeding, education, culture, and information from medical professionals.

Behavioral Beliefs are simply the beliefs women hold about breastfeeding. For example, in the current study, some participants expressed a belief that breastfeeding is natural. Another example is that a few mothers expressed the belief that based on their observation of others breastfeeding that formula-feeding might be more difficult due to less equipment preparation and cleaning. Such beliefs then inform the woman's

Breastfeeding Attitude

Normative Beliefs are perceptions of how others believe the woman should feed her baby which in turn inform a woman's *Subjective Norms related to Breastfeeding*. In the current study, participants identified several significant others as being influential in their decision to breastfeed. Some stated that their partners, family members, and medical professionals had communicated various reasons that they should breastfeed. The perception of the importance of such views also determines the woman's *Subjective Norms* related to breastfeeding. Though in the current study it seemed that most women

had made the choice to breastfeed independent of what others believed to be the right decision for them, implicitly, the women demonstrated congruency with the normative beliefs of these social influences.

Perceived Behavioral (Breastfeeding) Control is “the degree of anticipated ease or difficulty of breastfeeding and confidence in the ability to carry out breastfeeding” (Wambach, 1997, p. 52). This is derived from the beliefs of control related to breastfeeding. Women in the current study demonstrated high perceived behavioral control. They frequently indicated an expectation that their bodies were capable of breastfeeding, and most expressed the belief that if they persisted, they would eventually be successful in stabilizing breastfeeding. These reflections indicate the beliefs that they had a high degree of control of breastfeeding.

The next phase of the TPB model illustrates how *Attitudes*, *Subjective Norms*, and *Perceived Behavioral Control* impacts the *Intention* to engage in the behavior which then impacts engagement in the *Behavior* itself. Due to breastfeeding being an act that requires repetition and management of barriers, the current study’s integrated model extends the TPB *Behavior* component to two parts: *Breastfeeding Initiation* and *Breastfeeding Continuation and Stabilization*.

Integrating the Theory of Planned Behavior with the Alignment and Attunement Model

Thus far, the TPB appears to be a framework that adequately demonstrates the factors that impact a woman’s decision to breastfeed. However, the current study, as well as previous research on breastfeeding, suggests that the TPB overlooks a significant component of a woman’s breastfeeding trajectory. I will now explore how partner

involvement can be integrated with the TPB to better explain the process of breastfeeding decisions and outcomes. Though the TPB includes examination of internal and demographic factors, it does not place emphasis on the close relationships in an individual's life. As such, the role of the partner in the breastfeeding journey is minimized. Incorporating the current study's Alignment and Attunement model can support a broader and more accurate picture of breastfeeding initiation and continuity.

Integrating components of the model, such as the *Partner Alliance* and *Partner Attitude* illustrates how the couples' relationship and partner involvement is integral to the decision to initiate and continue breastfeeding. Enhancing and highlighting the partner variables gives merit to the noteworthy impact they have on breastfeeding. This approach is consistent with other studies that have looked at health behaviors and such findings will be detailed below. First I will provide an overview of how the current study's findings can be incorporated with the TPB to form the Partner Alignment and Attunement and the Theory of Planned Behavior model (PAATPB).

In addition to the TPB components previously mentioned, the partner is also a variable in the intentions and behaviors related to breastfeeding. Since the current study's participants were in committed, long term, and stable relationships, this model is particularly applicable to such couples, however further research may potentially explain how negative partner involvement, or the absence of partner involvement would impact breastfeeding initiation and continuation. The PAATPB incorporates five new areas (designated by ovals in Figure 1.0) with the 10 original TPB components (designated by rectangles).

The first added component is *Partner Attitude toward Breastfeeding*. This is composed of the partner's preconceived notions of breastfeeding based on past experiences as well as the ongoing changes of attitude based on the following influences. There is a bi-directional relationship between the *Partner Attitudes* and the mother's *Attitude*. For example, in the current study, several participants noted their partners had held a neutral stance toward breastfeeding, and then became more positive toward it as they learned about the benefits.

In addition, the *Partner Attitude* has a reciprocal relationship with the woman's *Intention to Breastfeed*. The current study showed that as women explicitly identified and enacted an intention to breastfeed, *Partner Attitudes* were increasingly accepting. A third bidirectional relationship is that *Partner Attitude* also impacts and is impacted by the *Partner Alliance*. The *Partner Alliance* is the PAATPB's main novel component. The subcomponents include *Responsiveness and Presence, Involvement and Support of Breastfeeding, Focus on the Baby and Teamwork, Intentional Communication, and Nurturing of the Partner Relationship*. The *Partner Alliance* component encompasses the dynamics of the partner relationship, such as how responsive, communicative, and involved partners are with one another. These relationship dynamics influence the *Partner Attitude* and vice versa.

Another addition to the TPB is an emphasis on *Partner Responsiveness to Breastfeeding Barriers and Changes*. The creation of this component highlights two areas that the current study's participants deemed to be influential in breastfeeding. The first is the significance of the partner's support in working through the various challenges that arise in breastfeeding. Every participant expressed how their partner provided

instrumental and emotional support that contributed to their persistence in breastfeeding. For example, some partners were skillful in communicating practical information learned from medical professionals to overcome latch difficulties while others vocalized encouragement and gratitude through these difficult stages. A few participants even expressed uncertainty of whether or not they could have continued breastfeeding if their partner had not been so involved and supportive. This component also addresses partners' responsiveness to the many changes related to breastfeeding that arise, such as the function of the woman's body and how this impacts the emotional and sexual relationship between partners. Partners' receptiveness in addressing such barriers related to breastfeeding was often mentioned as being central in the breastfeeding journey. Therefore, although the *Partner Responsiveness to Breastfeeding Barriers and Changes* component is an offshoot of the *Partner Alliance*, its integral role warrants a distinct component label.

The last additional component in the PAATPB is not specific to partner involvement; however, it is a finding in the current study that the TPB does not adequately cover. Though not a primary focus of the interview questions, all women expressed that the *Resources* they had access to impacted their *Intention, Initiation, and Continuity* of breastfeeding. These resources included access to medical care and support such as lactation consultants, financial means, and social support such as peer lactation support, friends, and family. In addition, women also spoke to their psychological resources, such as their ability to be resilient and be high-functioning despite fatigue and challenges. Lastly, these women had the physical resources to be able to breastfeed. All women in the study had the physiological capacity to provide their infants with adequate

nutrition by way of their breast milk, and they also had the physical capability and health to engage in the act of breastfeeding.

Previous Research on the Theory of Planned Behavior and Breastfeeding

The following section provides further context for the rationale of modifying the existing TPB to highlight social factors with a literature review on utilization of the TPB model in health behavior research. Some researchers (e.g., Courneya, Plotnikoff, Hotz, & Birkett, 2000) have suggested that the TPB does not fully capture the social variables that are influential in the process of the execution of health behaviors. This issue is particularly pertinent to breastfeeding because of the importance of social and family influences on breastfeeding.

For example, Swanson and Power (2005) write that breastfeeding is a contentious issue in many cultures. Examples of controversy include whether or not it is positive or negative for the mother or baby, how long it should be done for, and if it should be permissible in public. These type of beliefs are social norms and they dictate group rules about what is considered to be socially acceptable behaviors. In the infant feeding literature, a range of social influences has been examined, including that of partner, family, and medical professionals (Raj & Plichta, 1998). However, there is limited research on the degree to which each of these types of social referents impacts women's feeding choices. Further, views on breastfeeding also vary cross-culturally and thus impact mothers' feeding attitudes and behavior. Swanson and Power (2005) note that such cultural influences are also not well studied.

However, previous research suggests that subjective norms do impact infant feeding decisions. Swanson and Power (2005) measured subjective norms and

breastfeeding intention and outcomes at birth and 6 weeks postpartum. They investigated at mothers' perceptions of their partner's, their own mother's, and midwives' and nurses' views at birth and 6 weeks postpartum. Their results demonstrate that the decision to breastfeed or formula-feed is influenced by social norms. Interestingly, their findings show that women who breastfeed perceived more social pressure to breastfeed than women who formula-fed, and women who formula-fed perceived more social pressure to formula-feed. In addition, women who breastfed beyond 6 weeks postpartum perceived the social referents as having "more pro-breastfeeding views than 'discontinuers'" (p. 280). The authors suggest that this implies that these women received more pro-breastfeeding support.

Swanson and Power (2005) also examined how variable the degree of influence the social referents had on breastfeeding decisions. They found that women who breastfed regarded partners' and nurses' views as more important than those who formula-fed. On the other hand, those that formula-fed regarded the views of 'people in general' as most important. The researchers suggested that their study has implications for how feeding information should be disseminated to families. They recommended partner inclusion in prenatal breastfeeding education programs early on, and also suggested that such information be taught to school-aged children due to the early development of such attitudes. Lastly, Swanson and Power (2005) suggested that future research examine "the impact of a new baby on the mother and partner's relationship, barriers to breastfeeding in public, and the impact of breastfeeding on social/family life" (p. 281). They stated that questionnaires may not sufficiently capture the experiences of women and they suggest such research be conducted with "a qualitative interview-based

approach [to] identify specific influences on normative beliefs during early stages of breastfeeding” (p. 281).

A related area in which TPB has received criticism is its lack of emphasis on social support in planned behaviors. Social support is defined as the assistance or support received from others (Courneya, 2000). For example, Courneya et al. (2000) noted that within the exercise literature, the subjective norms component has not adequately covered the social influences at play in the execution of health behaviors. They surmise that one reason for this may be that subjective norms are not as influential as other social factors. To reiterate, subjective norm is defined as an individual’s perception of pressure to conduct a certain behavior and the degree of others’ approval related to this behavior (Ajzen, 2002). Courneya et al. (2000) suggest that while subjective norms may play a role in health behaviors, social support may be stronger predictor of the intention and execution of the behavior. Due to the significant impact of social support on health behaviors, some researchers have chosen to replace the subjective norm variable with social support in examining the TPB model (e.g., Courneya et al., 2000; Strating, van Schuur, & Suurmeijer, 2006).

Using quantitative methods, Courneya et al. (2000) measured social support by asking participants, “How much support do you receive for participating in regular physical activity from the people closest to you?” Results showed that social support was a better predictor of exercise intention than subjective norms. Courneya and colleagues (2000) state that these findings suggest that when considering whether or not to engage in exercise, individuals are more reliant on social support than perceived social norms. In another study, VonDras and Madey (2004) also incorporated social support within the

TPB model in their investigation of attainment of health goals. Their findings suggest that social support and TPB components are related. In addition, results indicated that family and friend emotional and instrumental support, as well as social support network size, predicted goal attainment even after controlling for TPB variables.

Strating and colleagues (2006) examined a specific type of social support in their research on partner support and individuals with rheumatoid arthritis. In line with other health behavior research (e.g., Rhodes, Jones, & Courneya, 2002), they chose to replace the subjective norm component of the TPB with partner support in an attempt to better capture the social influences on behavior. They decided to focus on partner support as partners are typically in closest contact with the individual and often have the opportunity to provide frequent emotional and practical support. Strating et al.'s (2006) findings support their hypothesis that perceived partner support enhanced self-management intentions of their arthritis, regardless of participants' attitudes and perceived behavioral control.

The promising findings related to social support raise the question of whether or not the TPB adequately accounts for social support in health behaviors decisions and implementation. Ajzen argues that the TPB does effectively address social support because social support factors are accounted for in the background factors component of the model (Ajzen, 2011). However, for the purposes of current study's targeted behavior, the original TPB model provides an incomplete picture of breastfeeding intentions and behavior. Given the recursive nature of breastfeeding and the ever-changing circumstances that are present (e.g., latch pain, returning to work, restrictions of autonomy), including social support as a background factor omits its impact on these

changing dynamics. Thus, the current study integrates the role of the partner in several areas along the breastfeeding journey and not only prior to the intention to breastfeed. Further, most participants in the current study reported that their partner's ongoing responsiveness and involvement was integral to their ability to be persistent in breastfeeding, especially when barriers arose.

VonDras and Madey (2004) suggested that based on the significant findings related to emotional and instrumental support within health research, there is a need to enhance focus in this area. They further suggested that this can be done in integration with the TPB as well as independently as both avenues have demonstrated strong results. In addition, mental health research would also benefit from adopting such approaches given the benefits of social support on mood and relationship quality (e.g., Brunstein, Dangelmayer, & Schultheiss, 1996). Courneya et al. (2000) suggest that the emotional and instrumental support provided by close family members or friends may be the most important social influence on a variety of behaviors across many different contexts. Indeed this aligns with the current study findings as it pertains to partner support. VonDras and Madey (2004) call for two types of interventions to be implemented. The first is at an individual level with health interventions that “target the individual's attitudes, motivation, control beliefs, and articulation of plan-of-action to meet specific health goals” (p. 228). The second is at the interpersonal level in order to “target emotional and instrumental dimensions of functional social support that influence behavioral intention and foster health goal attainment” (p. 228). These individual and interpersonal interventions could potentially be applied to expectant parents in

counseling, within prenatal education, and during prenatal medical appointments to target parenting, partner relationship, and breastfeeding education.

Limitations

Though this study contributes to an understanding how relationship satisfaction and breastfeeding interact, there are several limitations. One significant limitation was that the sample was homogenous. Most of the sample identified as white and heterosexual, had a Bachelor's degree, and all identified as cisgendered. In addition, their relationship demographics were also homogenous with most being married, and all being in highly committed, stable, and satisfying relationships for over 6 years. In addition, most of the women reported being committed to breastfeeding prior to the birth and most indicated a strong ongoing commitment. It is possible that due to the nature of the study, which noted the topics of relationship functioning and breastfeeding in the recruitment ad, appealed to women who had high affiliation in each of these areas. Thus, the homogenous sample could be attributed to self-selection bias. According to CGT, the small sample size and homogeneity are not necessarily limitations (Charmaz, 2014). CGT does not seek to generalize and the study procedures followed recommended CGT protocol of ceasing data collection once saturation of data was reached and no new themes emerged. As such, per GT, these findings are considered to be exploratory and not explanatory.

Another limitation related to methodology is that only women were interviewed. Though women's perceptions were the target of study, partner input could have added an additional and enriching dimension. One of the participants had explicitly mentioned wishing her partner could help with answering a question that related to their relationship.

Although the women seemed confident in the accuracy of their responses, on a few occasions, some participants noted uncertainty about their partners' views. This occurred with implicit factors, such as perceptions of closeness and changes in the relationship. In one particular instance, a participant's partner happened to be passing by the room she was at the moment she was explaining how he would often help with positioning her nursing cover in public because he didn't want anyone to see her exposed. He enthusiastically interjected that his actual intentions for helping with the cover was due to his assumption that it helped her be more comfortable, and that he did not care either way. Such misperceptions are likely more common than even the closest and communicative of couples realizes.

Other methodology limitations in the current study were that women were asked to recall experiences that occurred up to 3 to 8 months before the interview, depending on the timing of the interview. This dependence on retrospective recall may have compromised accuracy of the information provided. A longitudinal design, even within the CGT approach could have alleviated this issue. In addition, a longitudinal design would serve to better track the changes in the transition to parenthood, breastfeeding progression, and relationship satisfaction, which was a partial aim of the study.

Researcher bias is another limitation inherent in GT. Though I was cautious and attentive to potential bias that could influence data collection and analysis, it is impossible to remove myself from the research. This is explicitly acknowledged in CGT as a function of the researcher being not merely an observer, but an instrument. In addition to the biases and identity markers I am aware of and noted in Chapter Three, despite my best efforts, there were certainly aspects of bias that escaped my awareness.

The collaboration with a peer debriefer and inquiry auditor served to enhance knowledge of bias that I may have otherwise missed. For example, the inquiry auditor identified bias in my description of the participants' breastfeeding persistence which I had not realized until I brought more attentiveness to reviewing and revising the language to be more neutral and value-free.

In addition, although the general interview questions were agreed upon by the research team and the dissertation committee, because I was the only interviewer, the data collection itself was inherently biased with follow-up questions that I was compelled to ask in the moment. While having only one researcher can serve to maintain consistency across interviews, it is likely that my interview style had bearing on how the participants answered questions. Though participants were not made explicitly aware of my identity markers, in order to establish rapport and to communicate genuineness, I expressed some of my own reactions (e.g., in response to a crying baby acknowledging that I understood they needed to take the time they needed). Thus, my interviewing style may have elicited different answers than another interviewer's style would have. An alternative approach to decrease bias for this type of study might be to have an additional interviewer, though this is a rarely implemented approach in GT.

Another limitation is that the members of the research team all identify as white, feminist, and have a background in the field of counseling. These markers also impact the make-up of the research design, the types of questions that were pursued, and the topics of interest. In addition, data analysis was impacted by the views and identities of the research team. While the GT procedures of constant comparison and theoretical sampling enables themes to emerge based on the participants' stories, the research team still very

much impacts how these stories come to light and how the many pieces of data are analyzed (Charmaz, 2006, 2014).

Charmaz (2014) notes a number of critiques that have levied against the use of interviewing as a research technique. Some of this criticism outright questions the accuracy of interview data. Charmaz (2014) summarizes these critiques by stating: “what people say may not be what they do, have done, and would do in the future. Interviews are performances that research participants give for particular purposes” (p. 78).

However, in line with CGT, data collection by way of interviewing is not intended to replicate reality, rather it is meant to examine information from perspectives to serve a specific purpose, such as exploring connections and themes. Nonetheless, a valid criticism of conducting interviews by phone to collect of data is that it excludes participants who do not have access to or ability to use a phone, due to factors such as financial means or limitations in hearing or spoken language capabilities.

Implications for Future Research

Based on the current study results, as well as existing literature, there are several directions of research that would potentially increase understanding of the transition to parenthood, relationship functioning and satisfaction, and breastfeeding. Given that the women in the current study were both highly satisfied and stable in their relationships and had persisted through breastfeeding challenges, a possible extension would be to further address the processes related to how satisfied and stable couples facilitate breastfeeding and how these facilitators can be implemented or developed with couples and families that differ in levels of relationship satisfaction and demographics. The model from the current study could potentially be translated into an empirically validated quantitative

measure that could assess the effectiveness of such facilitators and other actions as perceived by breastfeeding women. In addition, applying the model to a larger sample could refine the components of the model and extend the generalizability of the findings.

Doss and Rhoades' (2017) review on the transition to parenthood research and relationship functioning outlines several suggestions for future research in these areas. They note that there is now consensus that the transition to parenthood triggers a decline in relationship functioning for most couples; however, as years pass, relationship functioning stabilizes at a level comparable to non-parents. Doss and Rhoades' (2017) also note that some couples experience no changes or experience improvement in relationship satisfaction after the birth of a child. This aligns with the current study as well in which participants across the board either reported the same levels of satisfaction, or increased levels of satisfaction, particularly with feelings of emotional closeness and fulfillment. This was not measured formally but was repeatedly referenced and implied throughout the interviews. Future research could target consistently satisfied couples to more closely investigate the factors that may be lacking in couples who do experience a decline in relationship satisfaction during the transition to parenthood. Doss and Rhoades (2017) also state the need for future research to address experiences of couples who are not married, have adopted a child, conceived through in vitro fertilization, and same-sex couples.

A second implication for future research is studying mothers' perceptions of physical touch during the transition to parenthood. An aspect of breastfeeding that women in the current study noted, but has received little attention in the literature is experiencing sensory overload and a lack of ownership of one's body. For example, a few

women echoed the sentiment of a participant who expressed that when she was able to choose how to use her body after hours of breastfeeding through the day, she wanted to have a break from any additional physical touch. A webinar by Lactation Education (2014), a company that provides online education to health professionals, notes that La Leche League has coined this phenomenon “sensual overload” and that this is commonly reported in their peer-to-peer support meetings. Future research on women’s experiences with breastfeeding should endeavor to explore these reactions. A better understanding of this could lead to normalizing these feelings and decreasing the potential of feeling shame. In addition, a better understanding of this occurrence would provide partners with information that could help to support, navigate, and overcome such circumstances. In addition, for women at risk of breastfeeding cessation due to sensual overload, lactation professionals could suggest ways in which mothers can achieve more autonomy over their bodies, while not compromising milk supply. For example, they might suggest that other members of the family put the baby down to bed, or hold the baby so the mother can rest and have space from further physical contact. Additional research could also help determine how individuals differ in their levels of preference for physical touch.

Lastly, potentially the most significant area in which breastfeeding research needs to expand is with populations that are most vulnerable to having suboptimal access to breastfeeding resources. Research indicates that such populations include people of color, people of low socioeconomic status, and teen mothers (e.g., Jones, Power, Queenan, & Schulkin, 2015). In addition, there is scant research on breastfeeding within same-sex couples (Wilson, Perrin, Fogleman, & Chetwynd, 2015), couples who adopt or conceive via in vitro fertilization or surrogacy (Schnell, 2015; Wilson et al., 2015), and women

who have health and physical barriers to breastfeeding such as breast injury or augmentation (Schiff, Algert, Ampt, Sywak, & Roberts, 2014), and trans-identified individuals (Wolfe-Roubatis & Spatz, 2015). The literature on health behaviors (Courneya et al., 2000; Strating, van Schuur, & Suurmeijer, 2006) and the Theory of Planned Behavior (Ajzen, 1991) also supports the need for further research to address the range of influences on women's intention and engagement with breastfeeding.

Implications for Clinical Practice and Educational Programs

Results of the current study are aligned with previous research that indicates that relationship functioning and satisfaction during the transition to parenthood is largely dependent on the stability of the relationship prior to parenthood (e.g., Cowan & Cowan, 2000; Shapiro et al., 2000). This suggests that couples who plan to be parents would benefit from seeking resources in order to strengthen their relationship in advance of becoming parents. Research has demonstrated that interventions during pregnancy can also enhance relationship satisfaction in the transition to parenthood. For example, even a 2 hour prenatal class may be effective in achieving this effect. A study by Daley-McCoy, Rogers, and Slade (2015) examined a pilot psychoeducational class for expectant primiparous parents. The objective of the class was to normalize relationship functioning challenges that many new parents face and to teach techniques about how to respond to these changes. The main themes of the class included exploring expectations about parenthood and developing communication and problem-solving skills. Results revealed that the class was beneficial compared to results of a control group. For participants who took the class, women experienced less relationship satisfaction deterioration while men perceived less deterioration in couple communication and less psychological distress.

Another area of emphasis that has been studied in prenatal settings is interpersonal attunement. The current study is consistent with previous research (e.g., Shapiro et al., 2000; Siegel, 2007) that demonstrated that partner attentiveness and responsiveness is linked to relationship satisfaction. In the current study, this was displayed through behavioral and emotional means, such as partner involvement in childcare, as well as partner emotional attentiveness. A 4-week program for expectant primiparous couples called Mindful Transition to Parenthood (MTP) program developed by Gambrel and Piercy (2015) shows promise in the effectiveness of teaching such mindfulness-based relationship skills.

Findings from an MTP pilot program demonstrated that men reported better relationship satisfaction and mindfulness skills, and less negative affect, while the results from women showed no differences compared to a control group. The authors suggest that the program may have been more effective for men due to their increased need for social support in the transition to parenthood, and the increased need for men to learn and implement mindfulness-based relational skills. In addition, the authors suggest that a longer class may have increased the effectiveness of the program for women. Couples who had participated in the MTP program were asked to provide feedback and they indicated they would have preferred for the program to be longer. Past research does show that programs that are 6 weeks or longer and span the prenatal and post-birth periods are the most effective in producing desired changes (Pinquart & Teubert, 2010).

Given the positive experiences of couples in this program and of participants in other mindfulness-based prenatal and parenting programs (e.g., Dunn, Hanieh, Roberts, & Powrie, 2012; Vieten & Astin, 2008), such programs show promise in improving the

partner and parenting alliance. According to research in the field of interpersonal neurobiology, the skills of emotion regulation, acceptance, and perspective-taking that are taught in such classes are integral to healthy relationships (Siegel, 2007). These skills can also be implemented in individual and couples counseling for expectant and new parents.

With regards to clinical implications of breastfeeding interventions, the current study highlights the importance of breastfeeding self-efficacy in new parents. All women reported high self-efficacy prior to and throughout their breastfeeding attempts and continuation. However, most women expressed either momentary or concurrent ongoing uncertainty of their ability to continue breastfeeding at some point in their journey. Had these women not been so able to access resources such as partner support, educational and financial privilege, and a pre-determined persistence to breastfeed, these challenges may have led to breastfeeding termination.

A model proposed by Bowles (2011), the Extended Parallel Process Model, outlines how IBCLCs and other health professionals can effectively communicate and guide women through these struggles by enhancing BSE. She suggests that IBCLCs communicate that such barriers can be serious, but that they can be overcome by following through recommendations if she has the necessary resources to do so. Future research on breastfeeding interventions should closely measure how breastfeeding education delivery impacts initiation and continuation of breastfeeding, and should not overlook women's perceptions of such teachings. For example, Bowles (2011) notes that fear-based teaching can incite defensive avoidance, denial or reactance, and the barrier is unlikely to be overcome. In addition, even if a woman is able to successfully breastfeed

following such an intervention, this approach disregards the autonomy of the woman and undermines her rights to receive compassionate and patient-based care.

The current study also captured the need to consider the multidimensional nature of identity and roles, and how women's experiences of motherhood are often shaped by contextual influences. Dunn, Kalich, Henning, and Fedrizzi's (2014) study extends this notion to breastfeeding with their study on health professionals using a social ecological model framework. Using focus groups they asked participants about their perceptions of the decision to breastfeed. The questions specifically addressed "barriers and contributors to breastfeeding at the individual, interpersonal, community, organizational, and public policy levels" (p. 6). Themes identified as breastfeeding deterrents included discomfort with breastfeeding in the company of others, significant others' and peers' negative perceptions of breastfeeding, formula being considered as the cultural norm, and availability of free formula samples. Themes identified as breastfeeding facilitators were knowledge of benefits, significant others' and peers' positive perceptions of breastfeeding, participation in mom and baby social groups, and Baby-Friendly hospital practices. Future research should investigate parents' views and experiences of their decision to breastfeed, as well as barriers and facilitators beyond the initiation phase in order to improve services and resources for families that can improve the normalization and accessibility of breastfeeding.

Conclusion

The transition to parenthood is a time of complex and challenging new experiences and change for first time parents. It is also a time in which the quality of the partner relationship can largely determine how parents cope with such changes. This

study examined mothers' perceptions of how one of these prominent changes, breastfeeding, interacts with the partner relationship. The study also shed light on the underlying and overt processes involved in the transition to parenthood and the partner alliance, and how these elements contribute to breastfeeding initiation and persistence. Based on constructivist grounded theory methodology, data collection sought to invite the stories and perceptions of primiparous mothers' experiences of breastfeeding, the transition to parenthood, and the partner relationship. Through data analysis, several components of this process emerged as significant themes and an exploratory model was developed, *Alignment and Attunement: How the Partner Relationship Facilitates Breastfeeding and Family Cohesion*.

The components of the model are eight recursive processes: (a) getting on board: the decision to breastfeed, (b) holding on tight: perseverance through struggles, (c) focusing on the baby and teamwork, (d) role shuffling, (e) settling into the routine and roles, (f) nurturing the partner relationship, (g) feeling grounded, and (h) being present and responsive across systems. In particular, a significant finding consistent with previous literature is that partner support is related to mothers' breastfeeding self-efficacy. A novel finding highlighted in the current study is that partner involvement in breastfeeding enhances mothers' perceptions of relationship satisfaction, the partner alliance, and breastfeeding persistence. These findings provide areas of teaching and exploration that should be addressed with perinatal couples through prenatal and postpartum medical appointments, counseling, and other interventions related to parenting and breastfeeding support.

APPENDICES

APPENDIX A
RECRUITMENT ADVERTISEMENT

Earn \$30-\$40 to participate in a study about relationships and breastfeeding

Hello, my name is Jenn Munch and I am conducting a dissertation study that is exploring breastfeeding and couples' relationship functioning.

I am inviting mothers who meet the following criteria to participate:

- 3-8 months postpartum
- Currently primarily or exclusively breastfeeding your first biological child
- Living with a committed romantic partner who is also considered the child's parent

Participation in the study will involve:

- A short electronic survey
- A 1.5 - 2 hour phone interview in which you will be asked about your experiences and views related to:
 - breastfeeding
 - becoming a parent
 - your relationship dynamics (e.g., satisfaction, quality, intimacy)
- A possible short follow-up interview

As compensation for your participation you will receive:

- \$30 to be mailed immediately following the initial interview
- An additional \$10 for any follow-up interviews
- An emailed transcript of the interview

If you meet this criteria and are interested in sharing your experiences, please email me at **jamunch@gmail.com**. I will then send you a consent form which will provide you with more detailed information about the study. If you have any questions, please don't hesitate to get in touch with me. I am aware that this is a very busy time in your life, and every effort will be made to accommodate you and your baby's schedule. ☺

As someone who is passionate about advocacy and research related to the transition to parenthood, it is my hope that this study can contribute to developing effective educational and supportive resources for new families.

If you know someone who might be interested in this study, I would sincerely appreciate you passing along this information.

APPENDIX B

CONSENT FORM

THE UNIVERSITY of NORTH DAKOTA BREASTFEEDING AND RELATIONSHIP FUNCTIONING STUDY CONSENT FORM

THE UNIVERSITY OF NORTH DAKOTA CONSENT TO PARTICIPATE IN RESEARCH

TITLE: Primiparous breastfeeding women's perceptions of the interaction between breastfeeding and partner relationship functioning

PROJECT DIRECTOR: Jennifer Munch, M.A., C.L.C.

PHONE # 701-203-3878

DEPARTMENT: Counseling Psychology and Community Services

You have been invited to participate in a study about breastfeeding and couples' relationship functioning. The study is being conducted by Jennifer Munch, M.A., C.L.C, under the supervision of Kara Wettersten, Ph.D, from the University of North Dakota Department of Counseling Psychology and Community Services.

PURPOSE OF THIS STUDY

You are invited to be in a research study about breastfeeding and relationship satisfaction because you expressed interested in participating. You are eligible to participate in the study if:

- You are (or soon will be) a first time mother of a three to eight-month old infant
- You are living with an individual who you consider to be your partner and the infant's other parent.
- You have been and are currently exclusively breastfeeding your infant. In other words your infant's primary source of nutrition is your breast milk.
- You are willing to complete a demographics form and engage in a two hour interview, and possible follow-up interview about your breastfeeding and relationship experiences

The purpose of this research study is to investigate first-time mothers' perceptions of the interaction between breastfeeding and a couples' relationship. It is hoped that the current study can ultimately inform future interventions related to educating and supporting new families.

DURATION OF THE STUDY

Your participation in the study will last approximately four months. You will be asked to complete a demographics form that will take about ten minutes to complete, as well as participate an initial interview that will last about two hours. Following this, you may be asked to participate in a shorter follow-up interview of approximately thirty minutes. Interviews will be done via Skype, by phone, or in person.

WHAT WILL HAPPEN DURING THIS STUDY?

You will also be asked to complete a one page demographics form via email. Upon meeting study criteria, an interview will be scheduled at a time that is convenient for you. During the interview(s), the researcher will ask you to describe your perceptions of breastfeeding and your relationship. Examples of topics that will be asked about include you and your partner's perception of relationships changes, closeness, intimacy, satisfaction, and quality, and how breastfeeding has impacted various areas of your relationship. During any time, you are free to let the interviewer know if you would prefer not to answer a question, or if you would like to withdraw from the study. You will be sent a copy of the interview transcript and invited to contact the researcher with any questions you have. You will then possibly be asked to participate in shorter follow-up interviews.

CONFIDENTIALITY

Your interview will be kept private and confidential. The only people that will have access to your interview are the research team and those who make sure research participants are treated fairly (IRB auditors). Additionally we will remove all identifying information from your transcripts to further protect your confidentiality. However, please note that confidentiality cannot be guaranteed via email communications. The interviews will be audio-recorded, but your name will not be on the recording, nor will it be associated with the study material in any way. We will ask for your name and mailing address for the purposes of mailing you your compensation checks only, this information will be stored separately from and not linked to your transcripts and audio recording.

The interviewer will be in a private office during interviews and we encourage participants to also be in private locations during the interview in order to protect your privacy. After the initial meeting, the interviewer will transcribe the audio recording.

Your data will not be stored with the consent form and will not include any identifying information. All materials will be kept electronically in password protected files. You

will be provided with a transcribed, electronic file of the interview which you may review and you can ask the PI to remove or alter anything you wish. One of the key features of a qualitative study is the use of direct quotes in order to illustrate the experiences of participants and to do so in a way that does not reveal the identity of participants. In a written report about this study, we will include selected quotes from interviews which highlight significant experiences. However, when you review the transcript, you may contact the researcher to ask that any information be removed.

Following data analysis, the electronic audio recordings will be deleted, as will any email correspondence. Electronic data such as transcribed interviews, will be deleted after three years and any hard copies of data will be shredded after three years. Consent forms will be deleted and/or shredded after seven years.

It is important for you to know that the researchers in this study are required by the state of North Dakota to report child abuse. If the information you give us suggests that child abuse is occurring, we are required by law to make an appropriate report to Child Protective Services. Likewise, if we believe you are in imminent danger of harming yourself or someone else, we are required to seek help on your behalf.

RISKS OF THE STUDY

There is minimal risk anticipated for participating in this study. Some questions may be uncomfortable for you due to the personal or sensitive nature of the topic.

If, however, you become upset by questions, you may stop at any time or choose not to answer a question. If you would like to talk to someone about your feelings about this study, you are encouraged to utilize <http://locator.apa.org/> to find a mental health professional within your region.

BENEFITS OF THE STUDY

Possible benefits of the study are that you will enjoy or appreciate the time spent discussing areas of your life that are significant to you. In addition, reflecting on the interview question topics may increase your awareness of challenging and important experiences and this may allow for you to recognize progress you have made or changes you wish to pursue.

In addition, we hope that, in the future, other people might benefit from this study because we will know more about how breastfeeding impacts relationships and this may inform interventions for new families so that they are able to be better educated and supported through the transition to parenthood, and with breastfeeding.

COMPENSATION

You may be paid \$30 total for being in this research study. You will be mailed a \$30 check upon completion of the initial interview and an additional \$10 for a follow-up interview.

Your participation is voluntary. You may choose not to participate or you may discontinue your participation at any time without penalty or loss of benefits to which you are otherwise entitled.

If you decide to leave the study early, we ask that you contact the researcher at 701-203-3878 or jamunch@gmail.com. If you leave the study before or during the initial interview, you will not be eligible to receive compensation. If you leave the study following the interview, you will be eligible to receive the \$30 compensation.

CONTACTS AND QUESTIONS

The researcher conducting this study is Jennifer Munch, M.A., C.L.C. under the supervision of Kara Wettersten, Ph.D. At any time, if you have questions, concerns, or complaints about the research please contact Jennifer at 701-203-3878 or jamunch@gmail.com, or Dr. Wettersten at 701-777-3743 or kara.wettersten@und.edu.

If you have questions regarding your rights as a research subject, you may contact The University of North Dakota Institutional Review Board at (701) 777-4279.

Your typed signature indicates that this research study has been explained to you, that your questions have been answered thus far, and that you agree to take part in this study. Please keep a copy of this form for your records.

Signature of Subject

Date

APPENDIX C

DEMOGRAPHICS SURVEY

Survey

Please put an "X" next to or highlight the correct answer.

1. Have you primarily breastfed your biological infant?

YES or NO

2. Are you currently exclusively breastfeeding (inclusive of bottle-feeding your breast milk)?

YES or NO

3. Are you living with a romantic partner who is considered the infant's other parent?

YES or NO

4. How long have you lived with your partner? (e.g., 1 year and 6 months) *Please type answer below.*

5. How long have you been in a relationship with your partner? (e.g., 1 year and 6 months) *Please type answer below.*

6. What is your infant's age? *Please type answer below.*

7. What is your age? *Please type answer below.*

8. What is your partner's age? *Please type answer below.*

9. Have you been a caregiver for a child you lived with prior to living with your infant? *Please put an "X" next to or highlight the correct answer.*

YES or NO

10. What is your sexual orientation? *Please type answer below.*

11. What is your partner's sexual orientation? *Please type answer below.*

12. If applicable, what is your occupation and/or employment status? *Please type answer below.*

13. If applicable, what is your partner's occupation and/or employment status? Please type answer below.

14. Please specify (type in) the ethnicity you most closely identify with or check answer below:

<input type="checkbox"/> African American	<input type="checkbox"/> Asian American
<input type="checkbox"/> Caucasian American/White	<input type="checkbox"/> Latino/Hispanic American
<input type="checkbox"/> Native American	<input type="checkbox"/> Other (please specify) _____

15. Please specify (type in) the ethnicity your partner most closely identifies with (to the best of your knowledge):

<input type="checkbox"/> African American	<input type="checkbox"/> Asian American
<input type="checkbox"/> Caucasian American/White	<input type="checkbox"/> Latino/Hispanic American
<input type="checkbox"/> Native American	<input type="checkbox"/> Other (please specify) _____

16. Which best describes your family's income? Please put an "X" next to or highlight the correct answer.

Under \$15,000
 \$15,000-25,000
 \$25,000-40,000
 \$40,000-60,000
 \$60,000-90,000
 \$90,000-120,000
 \$120,000-150,000
 \$150,000+

17. Do you or your partner have a personal or family history of mental illness? Please type answer below.

18. What is your level of education? Please put an "X" next to or highlight the correct answer.

<input type="checkbox"/> 8 th grade or less	<input type="checkbox"/> Partial college
<input type="checkbox"/> Partial high school	<input type="checkbox"/> College degree: _____
<input type="checkbox"/> High school degree/GED_	<input type="checkbox"/> Some graduate training
<input type="checkbox"/> Business/tech. school graduate	<input type="checkbox"/> Graduate degree: _____

19. Are you currently in school? Please put an "X" next to or highlight the correct answer.
YES or NO

20. What is your partner's level of education? Please put an "X" next to or highlight the correct answer.

<input type="checkbox"/> 8 th grade or less	<input type="checkbox"/> Partial college
<input type="checkbox"/> Partial high school	<input type="checkbox"/> College degree: _____
<input type="checkbox"/> High school degree/GED_	<input type="checkbox"/> Some graduate training
<input type="checkbox"/> Business/tech. school graduate	<input type="checkbox"/> Graduate degree: _____

21. Is *your partner* currently in school? Please put an "X" next to or highlight the correct answer.
YES or NO

22. On a scale of 1 to 5, please rate how religious you consider yourself:

Not Religious at all

1

2

3

4

Very Religious

5

23. Please note the mailing address you would like the check mailed to.

Thank you so much for filling this in! ☺

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