

The role of fathers in breastfeeding: decision making and support

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Abstract

Background: In recent years closer attention has been paid to the role of fathers in both the decision about whether to breastfeed and in supporting a breastfeeding mother. This qualitative study explores couples' decision making regarding infant feeding, parents' views on the father's role in relation to breastfeeding, and examines some dilemmas fathers face when supporting a breastfeeding partner.

Methods: Eighteen men and women using maternity services at the Royal Sussex County Hospital were interviewed by telephone.

Results: Fathers acknowledged that the decision to breastfeed should be made by the mother and a father's role was to endorse his partner's decision and provide practical and emotional support. Those who faced breastfeeding difficulties described the processes involved in deciding whether to continue.

Conclusions: This small study draws upon the views of men and women living in the south-east of England in a city with high rates of breastfeeding initiation. Findings may not be generalizable to the wider population. However, in this setting new parents need information about breastfeeding and support to make informed decisions about duration and further input from health professionals when facing difficulties.

Key points:

- It has been established that paternal support has a positive impact on initiation and duration of breastfeeding
- Participants in this study acknowledge the dominance of mothers in the decision to breastfeed
- In their view the role of the father is to care for and support his breastfeeding partner
- Fathers reported facing a dilemma supporting women who experience breastfeeding difficulties as they do not want to undermine her efforts but wish to protect her from the pain and exhaustion some women experience

Exclusive breastfeeding for the first 6 months of a baby's life is recommended as optimal by the World Health Organization (WHO) (2003) and endorsed by the UK government (Department of Health (DH), 2010). Yet breastfeeding rates in Britain are low compared to most other European countries (Organization for Economic Cooperation and Development (OECD), 2009) and, in developed countries, most women do not continue breastfeeding for 6 months after their baby's birth (Callen and Pinelli, 2004). There are many examples of interventions aimed at promoting and supporting breastfeeding (Fairbank et al, 2000; Chung et al, 2008; Meedya et al, 2010) but they have not had sufficient impact to alter social norms regarding infant feeding in the UK. Breastfeeding initiation rates have increased in recent years but cessation before 6 weeks after birth remains high and only about a quarter of mothers continue to exclusively breastfeed to 6 months (Griffiths et al, 2005; Bolling et al, 2007; NHS Information Centre, 2011). The primary aim of the study was to evaluate an intervention to provide fathers with information about breastfeeding. The sample was drawn from a city in the south-east of England where breastfeeding initiation rates are high and the majority of participants were in their 30s and well educated. These findings may not

be generalizable to other parts of the country, and they point to the need for further research with a broader regional remit.

Choice of infant feeding method

Evidence suggests that the choice of infant feeding method is made early in pregnancy, before contact with health professionals, or even prior to conception (Shepherd et al, 2000; Earle, 2002) and that intended feeding method is predictive of method at discharge from hospital (Scott et al, 2004). A number of factors have been seen to positively influence both the likelihood of a woman breastfeeding and breastfeeding duration reports. These include socio-economic status, educational level, ethnicity, age and marital status (Griffiths et al, 2005; Meedya et al, 2010). Women who breastfeed for longer periods are more likely to be older, married, more highly educated and better off financially. Psychosocial factors such as parental attitudes and values are also associated with both initiation and duration of breastfeeding (Shepherd et al, 2000). Differences in breastfeeding practice are seen among mothers from different ethnic groups (Griffiths et al, 2005) with white British mothers being less likely to initiate breastfeeding than all other groups including those described as 'other white'. However, Scott et al (2004) found no demographic variables independently associated with feeding method, suggesting that maternal attitudes are stronger predictors than socio-demographic factors. Three modifiable factors have been found to be positively associated with duration of breastfeeding (Meedya et al, 2010). These are intention, self-efficacy and social support. In a systematic review, Britton et al (2007) found that all forms of lay and professional support increased the duration of breastfeeding, including that offered by the baby's father, maternal grandmother, close friends and health professionals, while another study found that women who had little emotional support were less likely to be breastfeeding 3 months postpartum (Hoddinott et al, 2000).

In recent years closer attention has been paid to the role of fathers in both the decision about whether to breastfeed and in supporting a breastfeeding mother. Mothers who intend to breastfeed are likely to have a partner who has positive attitudes to breastfeeding. In a literature review, Meedya et al (2010) found evidence that a mother's attitude to breastfeeding and her perseverance with it correlated with both her partner's preferences and his support and encouragement. As with mothers, fathers' social and cultural attributes are associated with the likelihood of their partners' breastfeeding behaviour. There is evidence, for example, that women with partners who have lower socio-economic status (measured by income and educational level) are less likely to initiate (Dubois and Girard, 2003) or continue to breastfeed (Flacking et al, 2010) than those whose partners are better off and more highly educated. In response to this interest in the father's role, interventions have been designed to inform fathers about the benefits and practicalities of breastfeeding and there have been calls for a broader approach to breastfeeding promotion to include fathers, grandparents, health professionals and others within a mother's social network (Swanson and Power, 2005).

This article reports findings from a qualitative study which primarily aimed to evaluate the impact of a breastfeeding information pack targeted at fathers. This intervention was one of ten pilot projects funded by the Department of Health that made up the National Social Marketing Centre's learning demonstration scheme (National Social Marketing Centre,

2010), and was carried out in partnership with the Brighton and Hove Primary Care Trust. The evaluation found that the fathers' pack was broadly well received and that it provided some useful information and tips about breastfeeding for fathers. However, several other interesting issues emerged alongside those findings and are explored further here. This article focuses in particular on couples' decision making regarding infant feeding, parents' views on the father's role in relation to breastfeeding and some of the subtle dilemmas fathers face when supporting a breastfeeding partner. The authors suggest that these can have an impact on mothers' continuation of breastfeeding.

Methods

Sampling and recruitment

Men were primarily targeted for recruitment as the intervention was aimed at fathers. However, a number of women were also invited to participate to allow the research team to gather their views on the role of fathers in relation to breastfeeding. A total of 14 men and 4 women were recruited to the study. The majority of participants (11 men and 3 women) were recruited by a member of the research team at the Royal Sussex County Hospital in Brighton, either as they attended a 20-week scan in the ultrasound department, or following delivery in the postnatal ward. As many men accompanied their partners in both settings, researchers approached them there. Women whose partners were not present were invited to take part in the evaluation and asked to find out whether their partner would also be interested. Two people (one man and one woman) were recruited as they visited the same hospital for other reasons, one man via personal contact, and one man by specialist young parent health visitors based at a local Children's Centre. In the antenatal settings, those who reported having definitely decided not to breastfeed, and women without a partner, were not asked to take part in the study. In the postnatal ward, researchers took advice from midwives on which parents to approach and did not recruit those who were not breastfeeding or who were experiencing difficulties postpartum. Potential respondents in all settings were asked if they or their partner planned to breastfeed or if they had already started breastfeeding their baby, as appropriate. In line with the high proportion of women who initiate breastfeeding in Brighton and Hove (85.8% compared to 74.3% across England in the first quarter of 2011/2012) (DH, 2011), only a small number of mothers on the postnatal ward had decided against breastfeeding. Those approached were given an information sheet about the study and a copy of the breastfeeding pack for fathers. At the point of recruitment and before the actual interviews, researchers made it clear that participation was voluntary and participants could change their minds at any point. The researchers were sensitive to the fact that parents with a new baby may have other pressing priorities. Of those asked to take part, only one woman refused, saying that her partner would not be interested. Participants all gave written consent before being interviewed. Of the 35 people who initially consented to take part, just over half ($n = 18$) were eventually interviewed. Of those who did not participate, 12 either could not be contacted or a convenient time could not be arranged, and 5 changed their mind about taking part. Some of these mentioned having postnatal complications or difficulties breastfeeding.

Data collection and analysis Interviews were facilitated by a topic guide and recorded with participants' consent. Interviews were carried out by a member of the research team (BG) at a time convenient for participants. Four topic guides were developed for use in interviews

for men or women whose baby was not yet born and for men or women whose baby had arrived. Questions were open-ended and asked about general views on breastfeeding, decision making regarding infant feeding, fathers' role in breastfeeding and experiences of breastfeeding. Interviews lasted between 20 and 40 minutes. Interview data were coded thematically after repeated readings of the transcripts and comparison of accounts.

Results

Characteristics of participants

Fourteen men and four women took part in interviews. The mean age of male participants was 35.6 years (range 23–64 years; median 34.5 years) and the mean age of women was 31.25 years (range 18–41 years; median 33 years). Participants were asked when they left full-time education as a proxy indicator of socio-economic status. Two-thirds ($n = 12$) were aged 21 years or older when they completed their education, suggesting that they were educated to at least degree level or equivalent. Two reported leaving school at 16 years or younger. Two-thirds of participants ($n = 12$) were first time parents. All those interviewed had attended (during this or a previous pregnancy), or were planning to attend, antenatal classes provided by local maternity services, the National Childbirth Trust (NCT) and/or another local agency offering antenatal classes and breastfeeding support. Three reported attending classes for a previous pregnancy but did not plan to do so for the current pregnancy.

General views about breastfeeding

As might be expected given the sampling frame, virtually all those interviewed were positive about breastfeeding. Participants whose baby was not yet born were keen to breastfeed and those who had had babies by the time of interview were breastfeeding. Five parents who had had previous babies reported feeling forced to give up breastfeeding earlier than they would have liked for various reasons such as a tongue-tied baby, constant feeding, painful nipples, mastitis, and general tiredness and anxiety, but nonetheless were planning to breastfeed their new baby.

Men's responses suggested that they were reasonably well informed about breastfeeding, having read parenting manuals, attended antenatal classes, and learned from friends and family members. A few of those who expressed positive views on breastfeeding mentioned the health benefits for babies or mothers or both, such as the baby getting maternal antibodies, physical closeness and bonding with the mother, practical ease, and cost. However, the majority did not qualify their reasons, simply describing breastfeeding as something that they believed in or felt was the right thing to do. Despite this, a number of parents with young babies and those whose babies were not yet born articulated their lack of confidence about their ability to breastfeed successfully, seeing exclusive breastfeeding as optimal but not always achievable.

Deciding to breastfeed

The interviews explored how couples made the decision to breastfeed and especially the extent to which this had been a joint decision. As noted above, all those interviewed had already started or intended to pursue breastfeeding. Indeed, several participants said that as a couple they had more or less 'assumed' they would choose to breastfeed, seeing breastfeeding as customary in their social circle and because they were convinced of the

health benefits to the extent that they had not felt much need to discuss the matter at all. Infant feeding was reported as receiving relatively little attention in parenting advice literature, classes and elsewhere and (possibly as a result) in parental discussions, especially in relation to the overwhelming prenatal preoccupation with pregnancy and labour.

In 1979, Ann Oakley argued that 'like natural childbirth, natural infant feeding has become fashionable in a society that is technological 'by nature''. Despite relatively low rates of breastfeeding in Britain, this arguably remains the case, particularly amongst this well-educated cohort of parents living in the Brighton area. Earle (2002), for example, found an association in perception between feeding one's baby 'naturally' and being a 'good' mother, and a corresponding stigma attached to formula feeding with related feelings of guilt and failure. Two of the fathers interviewed for this study expressed their dislike of the imperative to breastfeed explaining that 'people can be a bit heavy-handed about forcing women to do it', seeing breastfeeding instead as a matter of personal choice and individual circumstances. An argument has been made that formula feeding can help increase fathers' involvement in early parenting—a Finnish study, for example, found that 54% of prospective parents wanted both parents to be able to feed their baby (Laanterä et al, 2010) and paternal involvement was seen as particularly important by those interviewed by Earle (2002) who had chosen to bottle feed. For some first-time parents the perceived 'naturalness' of breastfeeding possibly obscured any notion of problems, so that potential issues had not been discussed or anticipated. Those who had friends or family members who had experienced difficulties were better prepared but, even for them, when and how potential problems might occur could not be foreseen. Whether or not couples had discussed infant feeding, the majority of fathers felt that the decision to breastfeed should ultimately be 'the woman's call', as they perceived breastfeeding as primarily involving 'her body', time and energy. For this reason they said they would support the woman in whatever she chose to do:

'It was pretty much a joint decision but I would not have contested her decision. It's her body at the end of the day' (Male, age 27, first baby)

'... a joint decision but she has the casting vote of course' (Male, age 34, first baby)

'I don't think we [fathers] are entitled to [decide], to be quite honest. It's not our bodies.'
(Male, age 38, third baby)

Most of the men interviewed saw their role as supportive and enabling, rather than directional on this subject. To a degree this suggests that the decision to breastfeed or not was only perceived and operated as a joint decision to a limited extent. One father attempted to articulate how the decision was weighted between him and his partner:

'It's a joint decision ... 70:30 her decision, maybe 75:25. I totally agree with it but you can't force someone to do what they don't want to do' (Male, age 37, fourth baby)

These findings corroborate one of the conclusions of Sherriff et al (2009), that ‘the father’s role was more about supporting whatever decision the mother made, irrespective of their own views’. Participants in this study acknowledged, however, that there could be difficulties if couples held very different views on breastfeeding, such as the woman being in favour but the partner against, or conversely and arguably more tricky, if the woman did not want to breastfeed but the man was keen for her to do so. None of the couples in the study reported having differing views.

Duration of breastfeeding

For the majority of parents interviewed, the most common length of time that they intended to breastfeed was 6 months. The shortest period mentioned was 3 months. Several participants hoped to continue for about a year and one intended to maintain breastfeeding for 2 years as she had done with a previous child. The determining factors in relation to time period were a desire to follow the health advice received regarding duration (reported by many to be 6 months), and practicalities, such as the mother’s return to work. However, participants reported some degree of uncertainty and confusion as to the minimum optimum duration of exclusive breastfeeding and any potential consequences of stopping at, for example, 3 months or any added benefits of continuing beyond 6 months.

Fathers’ role in breastfeeding

Responding to questions about fathers’ role in breastfeeding, two main themes emerged.

Providing practical assistance to breastfeeding partners

Men in this study clearly saw their role as facilitating breastfeeding in practical ways as much as possible, although a few mentioned bottle feeding their babies with expressed mother’s milk as well. Such practical support included taking on more household tasks such as cleaning, cooking and looking after older children; and, more directly, providing drinks and food for the mother, helping her get comfortable for breastfeeding, winding the baby, and changing nappies:

‘She’s got two objectives: to look after the baby and to look after herself. My objectives are to look after everything else. If we fulfil those simple things then everything supposedly will be tickety boo’. (Male, age 35, first baby)

This ‘team’ approach, which has also been described by Rempel and Rempel (2011), was echoed by fathers who appreciated having a supportive role which enabled them to feel involved in the parenting project in the early months.

Providing emotional support

Previous studies have noted the importance to breastfeeding mothers of receiving emotional as well as practical support from their partners (Tohotoa et al, 2009). Encouragement, reassurance and acts of affection were all mentioned by fathers and mothers, as was anticipating a mother’s needs. One father talked about learning to: *‘second guess my partner’s needs and read the signals at any given time’.*

Study participants also mentioned the quality of their existing relationship affecting their ability to cope with the demands of caring for a new baby, suggesting that partners being able to communicate well gave each of them confidence to deal with the life changes they were facing. Pregnancy had prepared them to some extent for their new situation with one man stressing the importance of a man's 'loving, supportive role' in caring for a pregnant partner and then new mother.

Dealing with breastfeeding difficulties

Despite their positive views, some couples in this study encountered challenges in breastfeeding. Several participants reported facing significant feeding difficulties either with their new baby or with a previous child. Such problems included the baby not feeding easily, not gaining enough or actually losing weight, colic, difficulties sleeping, and for the mother, discomfort, mastitis, painful or cracked nipples, one breast not producing milk, sleep deprivation and distress. One mother reported having to bite down on a cloth because of the pain and another explained how nipple shields 'saved my life'.

Those who had had previous babies said they had approached this subsequent birth more prepared or, in other words, more aware that things might not go according to plan, and hearing accounts from others about breastfeeding difficulties had prepared two of the primagravidas. However, on the whole, for the first-time fathers in this study, the type, number and extent of difficulties and the distress involved came as a surprise.

Tohotoa and colleagues (2010) found that antenatal classes for prospective fathers dispelled the myth that breastfeeding, as a 'natural phenomenon', would not raise any difficulties. Although all those interviewed in our study had attended or were planning to attend antenatal classes and many had read other relevant material, awareness and preparedness for potential complications was generally lacking:

'At the beginning I didn't think it was going to be as painful as it was.' (Female, age 33, first baby)

Only one father reported that NCT antenatal classes had alerted him to possible problems, having previously thought:

'[...it was] only a matter of putting them on the boob and away they go.' (Male, age 32, second baby)

The choice faced by parents experiencing such difficulties was whether to stop breastfeeding sooner than desired, or to persevere despite the problems and, if the latter, to decide what other solutions to try, such as mixing formula feeding with breastfeeding. Those interviewed had followed a range of options, from stopping breastfeeding entirely, to using nipple shields, and topping up with bottled formula feeds. Nonetheless, for many persevering with exclusive breastfeeding for 6 months was said to be 'touch and go'. The men interviewed perceived their role as making life as easy as possible for the mother, but also reported feeling rather powerless in the face of these difficulties. They were unmistakably concerned both for the babies and for their partners and, in many cases, did not know what was the best course of action: to encourage her to persevere with

breastfeeding, or to advocate quitting and changing to formula feeding. While not wanting to undermine a mother's efforts, they also wished to protect her from the pain and exhaustion some women experienced. One father explained how he had had to 'soak up' his partner's 'hormonal stuff' without getting personally affected, describing how fathers sometimes had to 'do what they think they [mothers] need, which isn't always what you think'.

Overall, although all these fathers favoured breastfeeding over formula for their babies, they indicated that they would ultimately defer to the mothers' decision if she decided to stop. A feeling was expressed that, although men can 'influence' decision making, they were entitled to less than a half share, as they had no control over how painful or successful it would be:

'You can have your opinion but can't dictate how it's going to go.' (Male, age 34, first baby)

On further analysis minor distinctions in fathers' approaches were detectable, as they were in the initial decision about whether to breastfeed or not. Some fathers felt categorically that it was the mother's body and therefore totally her decision:

'The call is down to my wife; she has to do it' (Male, age 41, second baby)

'I'd never argue, only advise, on my wife's decision.' (Male, age 27, first baby)

Other fathers were slightly more equivocal and said that, although they would prefer if she continued to breastfeed, they would support their partner in whatever she chose. Yet others indicated that the man could indirectly encourage breastfeeding by making it as easy as possible for the mother by giving emotional and practical support, accompanying her to see a breastfeeding counsellor or health visitor, or by providing information about the overwhelming benefits of breastfeeding to encourage sticking at it. As evidence of the effectiveness of this approach, one mother explained that 'there were points where I really wanted to give up and would have if not for my husband'.

The 'orthodoxy' of exclusive breastfeeding among this group of parents made any decision to stop altogether or to introduce 'top-up' formula feeds (typically at night) difficult for most respondents, and anathema for some, particularly mothers. Fathers talked about partners' feelings of guilt and failure when they 'gave in' to bottle feeding and how they tried not to undermine her efforts to continue while supporting her to introduce formula feeding if that was what was recommended by health professionals. One woman explained how she welcomed her partner giving her 'license' to stop breastfeeding which paradoxically had the effect of encouraging her to persevere.

Discussion

The fathers interviewed for this study were universally supportive of their partners' attempts to breastfeed, even when difficulties were experienced. On the whole they felt it was ultimately the woman's decision to attempt breastfeeding in the first place or to continue to do so if it proved challenging, but that, in principle, they would support their partners to succeed. The interview data prompted us to question the extent to which

both partners could have an equal input into the process of deciding to initiate and continue with breastfeeding. Amongst participants in this study the overwhelming view was that, at least in cases in which there was a lack of consensus between parents, the woman had the casting vote. Effectively, the issue of who decides might only emerge where a couple's views differ to begin with, or where, as in some cases, difficulties arise once breastfeeding has been attempted. Again, when the woman wanted to stop breastfeeding but the man preferred to continue, the woman's view seemed to take precedence. The general opinion amongst our participants was that such asymmetry of decision making is justified by the woman's autonomous right to control her body, and by the fact that the greater part of the impact is felt by her.

Method of infant feeding is merely one of many parenting decisions that modern UK parents are expected to make. Others include the location and management of birth, a child's name, religion, and school. A distinction could arguably be drawn between those decisions covering pregnancy, birthing and feeding, which all involve and have an impact on the mother's body, and others, such as schooling or religion, which might be easier to consider as decisions equal to both men and women. The degree to which these decisions are actually made jointly will depend on numerous factors. They are likely to be dependent on a particular couple's communication, their relationship and its power dynamics and on cultural, educational and other variables. This is in keeping with the views of Deave and Johnson (2008) who argue that first parenthood marks an important developmental period from couple to family with important implications for women and for men.

Although a father's role in decision-making may be secondary to a mother's when it comes to infant feeding, the practical and emotional support he can provide may be essential to breastfeeding success. Practical assistance in the form of taking on household tasks and caring for older children was seen by participants to be valuable, as was ministering to the breastfeeding mother by helping to make her comfortable and, as Rempel and Rempel (2011) describe it, 'refuelling' her by providing food and drinks. Actively seeking relevant information and, when necessary, professional help were also acknowledged as important contributions. The emotional support offered by these fathers, in the form of affection, reassurance and encouragement, was also considered to be a significant factor.

Fathers were sometimes put into the potentially difficult position of supporting a woman to give up breastfeeding, or at least to introduce supplementary formula feeds and, in effect, to go against the received advice, information and cultural assumptions, while not undermining her determination to succeed. Some women facing difficulties were buoyed up by their partner's encouragement, reporting that his support had enabled them to continue to breastfeed when they felt like giving up. Fathers could also help assuage mothers' anxiety and guilt about introducing some bottle feeds by offering reasoned arguments for the use of formula and therefore giving license to introduce it.

As well as a father's personal inclination and ability to support a partner and child, external cultural factors are likely to also play a role: the fathers in this study could be viewed as closely involved in parenting and clearly saw it as their role to provide as much practical and emotional support to their partners as they could, while perceiving the decision to

breastfeed as ultimately the woman's right to control her own body. This cannot be presumed to be a universal approach: the implication being that with less support more women might not start, or might prematurely stop, breastfeeding.

Limitations

This is a small study which draws upon the views of men and women living in a city with high rates of breastfeeding initiation. The majority of participants were in their 30s and well educated. Findings should therefore be interpreted with caution.

Implications for practice

Health professionals should be aware of the important role fathers play in supporting women's decision to breastfeed and to continue breastfeeding even when facing difficulties. Fathers' involvement should be acknowledged and sources of breastfeeding information made available to both mothers and fathers.

Conclusions

This small study identified some issues for public health policy. The findings suggest that new parents—both mothers and fathers—need information about breastfeeding before a baby's birth, support to make valid, informed decisions on the optimal duration of breastfeeding and further input from health professionals when facing difficulties on whether or not to continue. Ready access to reliable information would be helpful if one parent was less keen than the other or if the woman had an open mind and her partner wanted to convince her or act as a 'sounding board' in the decision-making process.

Despite reporting being well-informed and enthusiastic to breastfeed, some of our participants had only managed to overcome breastfeeding problems with great perseverance, attempting to deal with the distress experienced and trying to find ways around their difficulties. Not everybody could or would persevere to this extent. Ultimately their determination was underpinned by perceptions that breastfeeding was optimal on many fronts.

The fact that most of the first-time parents were unaware of the potential difficulties associated with breastfeeding could be attributed to a number of factors. It is possible that parents filter out this information and are reluctant to acknowledge possible problems, or perhaps it gets lost in the plethora of antenatal information, or there may be a gap in the literature and advice provided. The latter in itself might be indirectly due to a fear among professionals of further discouraging parents from trying to breastfeed. The findings also call into question whether there is adequate and consistent information and support available for mothers experiencing difficulties with breastfeeding once home and for their partners in trying to support them.

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