ABSTRACT

FITZWATER GONZALES, LAURA BETH. Doing What’s Best for Baby: How New Mothers and Fathers Negotiate Breastfeeding Over Time. (Under the direction of Dr. Sinikka Elliott).

Public health discourses and medical experts frame U.S. breastfeeding rates as a social problem, arguing that not enough women breastfeed exclusively for the recommended six-month duration. Yet experts rarely consider the social contexts of women’s lives and the complex array of factors they contend with as they attempt to breastfeed. Through a longitudinal qualitative multi family member interview study with first-time married, heterosexual parents who were planning to breastfeed, I examine the ways new parents frame and experience the transition to parenthood and breastfeeding. Overall, I find that the parents in my study desire to do the best for their baby, and frame breastfeeding as the ideal way to nourish and nurture their infants.

The dominant breastfeeding discourse, particularly as it is endorsed by medical and public health experts, has real consequences for individuals, as women who do not or cannot breastfeed may feel guilty, judged, or stigmatized. The women I interviewed recognized that they would be held accountable for their infant feeding strategies. In chapter three, I analyze the experiences of women who faced temporary and permanent barriers to breastfeeding. By performing intensive mothering practices (Hays 1996)—specifically by pushing through pain, determining and prioritizing doing the best for baby, and working hard to breastfeed—these women attempt to fit into the dominant breastfeeding discourse and thereby claim the good mother identity.

Breastfeeding literature promotes bonding with baby as one of the primary benefits of breastfeeding, thus chapter four focuses on how parents create and protect the bond of
breastfeeding. Participants frame breastfeeding as creating a special bond with their child beyond a simple connection. Some families practice what I term family gatekeeping—drawing symbolic barriers around their nuclear family—to purposely and strategically exclude others from the bond. This chapter also delineates the practices that increase women’s invisible, mental labor in the family (Walzer 1998). I find that, prior to the baby’s birth, women take on a managerial family role, engaging in daddy worry and devising inclusion techniques to bring men into the bond. These practices provide insight into the ways inequality is reproduced within families, as women, not men, engage in mental worry work, creating a highly gender-unequal division of mental labor between women and men. Furthermore, I argue that these families’ practices may reproduce inequality between families, as families in socially privileged positions use their resources to make privatized and individualized decisions.

Chapter five analyzes the nighttime division of emotional and practical labor, what scholars term the fourth shift (Venn et al. 2008). Couples who develop a manager-helper dynamic—whereby women manage and men help when directed—divide the fourth-shift labor in highly gender-unequal ways. My findings broaden our understanding of how sleep disruptions are gendered, by uncovering the processes that underlie the gendering of the fourth shift among first-time heterosexual parents. These processes include women taking responsibility for childcare, doing research when necessary, and encouraging their partners to sleep through the night. I argue that these processes reinforce a gender-unequal division of labor that naturalizes men’s lesser and women’s greater roles in nighttime care, thereby reproducing inequality within families and more broadly, as women’s paid and unpaid labor are devalued.
I conclude the dissertation by calling for social policies that are more supportive of families, particularly as they struggle with decisions around childcare in the transition to parenthood. I argue that we need to disentangle care work from gendered beliefs, to reduce gender inequality within families, specifically, and society, more broadly.
Doing What’s Best for Baby: How New Mothers and Fathers Negotiate Breastfeeding Over Time

by
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A dissertation submitted to the Graduate Faculty of North Carolina State University in partial fulfillment of the requirements for the degree of Doctor of Philosophy

Sociology

Raleigh, North Carolina

2017

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DEDICATION

To the women and men who struggle to find their footing as parents.

Keep up the good work.
Laura B. Fitzwater Gonzales was born and raised in the Pacific Northwest. As a child, she lived in France for three years with her parents, in a small town in the heart of the Loire Valley. She credits this experience as the first of many that influenced the development of her sociological imagination. Laura received her bachelor’s degree in sociology from Seattle Pacific University. She spent two years running the children’s programs at a women and children’s homeless shelter in downtown Seattle, and then uprooted her life to pursue graduate work in sociology. Laura earned both her master’s and doctoral degrees in sociology at North Carolina State University. During this time, Laura met and married her husband, Brian Gonzales. They have two daughters, Claire and Mollie.
ACKNOWLEDGMENTS

In my experience, the work of completing a dissertation shares many similarities with pregnancy, labor, breastfeeding, and childrearing. They all require time, dedication, nurturance, patience, endurance, and strength. And most of all, they require a village. I would like to take this opportunity to thank the village of people who surrounded me the last nine years and made this journey possible.

First and foremost, none of this would have been feasible without the continual support and encouragement from my adviser and mentor, Sinikka Elliott. It is humbling to know that the person who has seen my writing at its worst has continued to read, edit, and push me forward to be a better sociologist and scholar. I am forever indebted to you, and grateful for the time and effort you took to work with me. I am also thankful for my committee members whom I had the of pleasure working with in different capacities during my time at NCSU. I appreciate all the time and effort you each put into my research, and for investing in me as a student and a scholar. And I will never forget that you all braved the snowy roads for my proposal defense, especially since the original defense date was postponed due to an ice storm! Michael Schwalbe, thank you for being on my committee and for caring about the minute writing details. You have always inspired me to be a better writer. Ted Greenstein, I have fond memories of all the graduate courses you taught and how much I enjoyed being in those classes. I am so thankful you were a part of my dissertation committee. And Michaela DeSoucey, thank you for taking such an interest in not only my research but also my professional development. Along with Sinikka, you pushed me to do
better and to get more done. I am so thankful for your professional tips and guidance the last couple years.

I was also fortunate to build relationships with other faculty and colleagues over the years at NCSU, and I appreciate these relationships and lasting memories. I am grateful to Maxine Atkinson for helping to hone my teaching craft and supporting my love of teaching. I loved every opportunity I had to teach at NCSU, and all the students I met in my classes. Thank you to Toby Parcel for not only working with me, but also providing support by facilitating the dissertation support group, from which I found much comfort and solace in the last years of my graduate studies. And thank you to Beth Overman Cauley, whom I was fortunate to know as a friend and colleague, and for the opportunity to complete the Mentorship and Teaching Practicum at NCSU. I would not have the professional opportunities I have today without that program.

During my dissertation research, I recruited Kayla Branch as an undergraduate research assistant. She worked on this project for eight months and logged over 142 unpaid volunteer hours, most of which were spent transcribing interviews. I sincerely appreciate this investment of her time and energy, especially because transcribing is such a tedious task. I would have been much further behind on transcriptions if it was not for her dedication to the work.

Additionally, I am grateful for the friendships that began in the hallways and offices of the 1911 Building and will hopefully continue for many years as we find our different fits in the academic world. I am particularly thankful for Emily P. Estrada, Rachel Cronmiller,
Scott Grether, Lindsay Hamm, Mindy Vulpis, Brandi Leach, Joslyn Brenton, and Aysha Bodenhamer. Your friendships made graduate school much more enjoyable!

To my friends from IVGCF, particularly those I met back when I started graduate school: Becca Thomas, Stewart Thomas, Brian Gonzales, Susanna Klingenberg, Bryan Klingenberg, Karli Bain, Erich Bain, Eric Butler, Ben Redelings, Beth Cauley, Jared Barnes, Jenny Pohlheber, Deanna Knighton, Casey Davenport, Keegan Davenport, Sam Boldenow, and Christina Ludema. I would not have survived graduate school without all of you! Thank you for years of friendship, laughter, cabin trips, potlucks, game nights (especially endless rounds of Dutch Blitz and Settlers—how I miss those nights!), celebrations, graduations, weddings, and now babies. It looks like I am the last to finish graduate school; I am excited to finally join you all on the other side! The problem with having such a great community of friends in graduate school is going our separate ways upon the completion of our degrees. I miss you all terribly, and I look forward to a reunion one of these days. I am incredibly blessed to know each one of you.

I also value the myriad support I received during the time I worked to complete my dissertation. I especially appreciate the sociology faculty at Meredith College—Amie Hess, Lori Brown, and Kris Macomber—for the opportunity to teach at Meredith, as well as the office where I was finally able to finish writing. You each provided many words of encouragement and support.

Additionally, I would have never come to NCSU if it was not for Jennifer McKinney at Seattle Pacific University. She sparked my interest in sociology when I took her undergraduate research methods class. And I am so glad she let me into the class, even
though I had not yet taken an introduction to sociology course! I will never forget that first
day of class my second year of college, and the profound impact Jennifer has had on my life.
I am so thankful for your friendship, mentorship, and guidance all these years. And while we
have not met (or read a book together) in years, I am grateful to the women of my sociology
book club—Courtney Irby, Jennifer McKinney, Courtney MacNealy-Koch, Joelle Hathaway,
Ellen Broweleit, and Emily Haddad—for the laughter and fun we shared over the years.
Thank you also to my closest friends, Sarah Adams and Valerie Slaybaugh, who stood by me
these last nine years, even though we were many miles apart. I am grateful for your
friendship, encouragement, love, and many, many phone calls. Finally, friends who shall
remain nameless unknowingly provided me with thoughts and ideas about breastfeeding as I
pursued the earliest avenues of this research. Thank you for sharing your opinions and
experiences, especially those that differed from my own.

I particularly want to thank the people who took care of my children for the past four
years—those who did the work of mothering—while, in addition to teaching, I was
interviewing, analyzing, researching, and writing. Thank you to Autumn Thornton, Erica
Smith, Kayla Grinnell, Sydney Thomas, and Ivy Marion for the love and attention you gave
to my girls. Thank you for keeping them safe, providing endless entertainment, and
encouraging their interests. And thank you to my wonderful parents, Don and Joy, who also
took care of the girls for a couple of weeks near the end. I could not have done it without
you!

Thank you to the 24 women and men who participated in this research. Thank you
for trusting me with your stories, for inviting me into your homes and your parenting
journeys. Thank you for your willingness to be interviewed during this crazy time of life, especially when things did not go as planned. Thank you for sticking with me through all the interviews. I am so grateful.

And finally, thank you to my family, who offered unending love and support. No one predicted the changes that would happen in the last nine years, many which have been wonderful. Thank you to my parents, Don and Joy Fitzwater, and grandparents, Don and Betty Fitzwater and Betty Jo Kenney (in memoriam), who consistently supported my pursuit of graduate school, even though it meant that I moved far away from home. And thank you to Brian, my husband and partner, who has been there for me each step of the way, always willing to listen to my excitement and frustrations. Thank you for sharing the work of parenting with me. And to my sweet Claire and Mollie, who inspired me to pursue this research. I love you all so much.
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CHAPTER 1

DOING THE BEST FOR BABY: INTRODUCTION

Why choose to breastfeed? Because it’s the healthiest thing for your baby. It’s an instant bond that no one else can have with your baby. Your baby will not get as sick, you will not get sick often. Everyone told me Jacob would be so sick during the winter, and he may have had one tiny cold. It’s so much easier than preparing a bottle! Even now when I have to give him a sippy cup or bottle of whole milk, it’s a pain to go get that while he’s fussing! If you breastfeed you always have food for your baby! If you are stuck somewhere (let’s say your car breaks down) you have food for your baby! Honestly, I do believe breastfeeding makes someone a good parent. If you tried to breastfeed and for whatever reason you just couldn’t, you’re still feeding and nourishing your baby, and you are a good parent. The point is trying! So many just give up! That I do not understand. It’s about being self-less. Why have a child if you’re not going to give them the best? - Catherine, one year written follow-up

INTRODUCTION

According to public health organizations and medical experts, breastfeeding—or, to be precise, the lack thereof—is a social problem. Organizations such as the American Academy of Pediatrics (AAP) and the World Health Organization (WHO) recommend that women exclusively breastfeed for at least six months (WHO 2017). Yet in 2016, while 81.1 percent of U.S. mothers attempted to breastfeed at least once, only 44.4 percent of infants exclusively breastfed at three months, and 22.3 percent exclusively breastfed at six months (CDC 2016). Thus, despite recommendations from the medical experts, and despite the finding that women privilege medical advice (Andrews and Knaak 2013), the percent of mothers actually following this advice is relatively low. Public health organizations such as the Centers for Disease Control and Prevention (CDC) aim to increase national breastfeeding rates through support efforts such as increasing the number of La Leche League leaders and lactation consultants per state (CDC 2016). In 1991, the WHO and UNICEF launched the
Baby-Friendly Hospital Initiative (BFHI), a global effort to promote and support breastfeeding practices. Their website states that the BFHI “has measurable and proven impact, increasing the likelihood of babies being exclusively breastfed for the first six months” (WHO 2017). Additionally, medical experts such as the AAP promote breastfeeding as the best nutrition for babies, superior to infant formula. In *Pediatrics*, the journal published by the AAP, Bartick and Reinhold (2010) estimate that the U.S. incurs $13 billion in excess medical costs and sees 911 preventable deaths per year because women are *not* breastfeeding. Another article states: “strategies that increase the number of mothers who breastfeed exclusively for about six months would be a great economic benefit on a national level” (Eidelman and Schanler 2012: e832). Thus, according to these health experts, breastfeeding is the way to save our nation, both literally and financially. And the burden to do so is on mothers.

When participants in my longitudinal study of breastfeeding intentions and practices discussed where their knowledge of breastfeeding came from, they often made statements similar to Andrea, who said at the first interview, “Everyone in this day and age says that the breast is best, you can’t go to any website or read any book or talk to anybody without having that encouragement or promotion. So I’d say it’s everywhere. I don’t know if it’s any one particular source.” Many participants explained that they had often “just heard” or “just read” the things they knew about breastfeeding. As Andrea indicated, the “breast is best” maxim is difficult for expectant parents to avoid, a large reason for this being that medical experts encourage new mothers to breastfeed.
Medical and scientific experts’ endorsement of “breast is best” is a part of “scientific motherhood” whereby mothers are expected to sift through and decide which advice they should follow for optimal health (Apple 2006). Not only do cultural discourses of mothering position mothers as ultimately responsible for their children’s short- and long-term health outcomes (Hays 1996), but mothers also must contend with the experts’ discourse of risk, and the ways mothers are responsible for avoiding risks for their children at all costs (Knaak 2010; Lee 2007; Murphy 2000; Stearns 2013; Wolf 2010).

THE STUDY

I began this chapter with a quote from one of my participants, Catherine, a middle-class white mother in her late 20s. Out of the twelve couples I interviewed who anticipated breastfeeding upon the birth of their first child, Catherine was the only mother to have a breastfeeding experience that did not involve extensive pain. She did not have reoccurring mastitis or health problems, her baby’s weight gain was not a concern to the pediatrician, she did not have issues getting her baby to latch to the breast, and she never used infant formula or other human milk for the first year of her baby’s life. The other eleven mothers faced one or several of the above challenges, and all of the other families used at least some formula to supplement the mother’s breastfeeding during the first year. Catherine’s experience, as she discussed it in the opening excerpt, mirrored the dominant breastfeeding discourse—one that is expert-endorsed and focused on the baby’s health and wellbeing—as well as the ideology of intensive mothering (Hays 1996). Breastfeeding is healthy, it promotes mother-child bonding, it is easy, always available, requires sacrifice and selflessness, and it is the best for
baby. As I illustrate throughout this dissertation, these beliefs about breastfeeding were widely held by my participants, yet my analysis reveals the processes underlying breastfeeding and couples’ parenting practices that reproduce inequality within and between families. Catherine ultimately quit her job and did not return to full-time work while her husband, Shawn, began to work six days a week as the sole provider. Catherine took on the bulk of the childcare while Shawn did very little. Although Catherine saw health benefits for her son in her ability to continue to breastfeed, this arrangement is one that is not available to most families and also one that involved a highly unequal division of labor within this couple’s household.

I began this research as a committed breastfeeding mother, firmly believing in the health benefits of breastfeeding, and I spent the duration of my dissertation research pregnant and/or breastfeeding. I breastfed both my children past the age of two, and I never used infant formula. In my own practice, I have enacted the “breast is best” dictum. Although I began this work as a biased insider, my research has enabled me to see that the public health discourse around infant health is largely socially constructed based on current ideas surrounding infant feeding and mothering. Moreover, these health discourses have become moralizing discourses. While parents seek to do the “best” for their child, if mothers do not breastfeed, they are often shamed and judged for putting their children at risk, for denying them the best, and for being selfish. The dominant ideology of intensive mothering permeates breastfeeding promotion discourse, providing a blueprint for mothers to follow if they want to give their children the best: breastfeed your child on-demand, do so exclusively
for at least six months, and continue ideally for a year or more. Mothers who do not meet these standards struggle to figure out what it means to be a good mother.

In 2013, I set out to interview soon-to-be new parents—many of whom had access to myriad resources because of their high incomes, education, and statuses—about their ideals and plans around infant feeding. Before their baby’s birth, all the parents were planning to exclusively breastfeed as this was a study criterion. Upon birth, all of the women initiated breastfeeding, and all of them experienced a range of challenges, which I learned about when I reinterviewed each member of the couples two to seven weeks after the birth. For most of them, breastfeeding was not easy, and for all of them, breastfeeding was a time-consuming endeavor. By the time the babies were six months old, when I conducted a joint interview with both members of the couples, half of the babies were consistently receiving a formula supplement along with breast milk, and one mom had stopped breastfeeding altogether. These couples’ narratives enlighten our understandings of the processes underlying parenting decisions and practices, especially as they pertain to breastfeeding.

Throughout my interviews with expectant and new parents, I found they expressed a consistent desire to do what was best for their baby, yet when breastfeeding did not go as planned, they struggled to figure out exactly what was the “best” choice. It is not surprising that parents want what is “best” for their babies, their children, and their families given the dominant discourses that promote this idea. Additionally, as medical experts are framed as the experts on babies—rather than parents—mothers and fathers strive to follow expert advice (Apple 2006). For example, when I asked Rachel, another participant, at the second interview about why she wanted to breastfeed for one year, she said, “Because that’s just
what they say. I have very little reasoning behind anything that I’m doing, but that’s what they say.” I asked her, “Who’s they?” and she responded, “They, um, that’s what the doctor told us to do, and the lactation consultant, and that’s what it looks like from our little books that we’re reading that [breastfeeding for a year] would be best.” Mothers hear and want to adhere to expert advice. As Faircloth (2013) quotes from a talk given by Rima Apple, “What mother would want to risk the health of her baby by not doing ‘the best’?” (40). When expert advice is framed as the best, mothers must follow it, otherwise they are blamed for less-than-ideal outcomes and held ultimately responsible for their child’s well-being (Hays 1996). Fathers are not held to this same standard; their moral identities do not rest on their parenting skills and responsibilities in the same way that mothers’ moral identities do.

In this dissertation, I examine the way new parents frame family decisions around doing what’s best for the baby. My analysis reveals how inequalities are reproduced within and between families through myriad, everyday decisions and actions. Inequality is reproduced between families as families in socially privileged positions—white, married, middle and upper-middle class—use their resources to make privatized and individualized family decisions. Additionally, gender inequality is reproduced within families as couples, facing a moral imperative to breastfeed, come to divide family responsibilities, including practical and emotional demands, in unequal ways. In what follows, I review the literature on the transition to parenthood and the gendered division of labor. I then discuss how breastfeeding is a practice that reflects the ideology of intensive mothering. I conclude this chapter with a roadmap of the dissertation.
TRANSITIONS TO PARENTHOOD AND THE GENDERED DIVISION OF LABOR

Becoming a parent can be shocking, startling, and overwhelming. LaRossa (1986: 114-115) states about parenting:

What really makes a difference in your life once you have a child is the responsibility of having to care for—and be accessible to—someone who needs you. It is this more than anything else that restructures the social world of new parents; and it is this more than anything else that makes parenthood one of our most important social institutions.

Although LaRossa refers to “new parents,” in this transition to parenthood, women are expected to assume primary responsibility for children, not only for their immediate care, but their short- and long-term outcomes (Hays 1996). The effects of parenthood begin even before the birth of a baby, as women are more likely than men to worry about how they will combine parenthood and their career even before becoming pregnant (Bass 2015).

People’s attitudes are not stable over the life course, instead, they change depending on life experiences and events (Baxter et al. 2015; Coltrane 2000; Lam, McHale, and Crouter 2012). The introduction of a baby into a household marks one such life event. Numerous studies document how, after the birth of a baby, heterosexual couples become more gender specialized in terms of their care work and paid labor (Baxter et al. 2015; Bianchi et al. 2000; Cowan and Cowan 1992; Craig and Powell 2011; Gjerdingen and Center 2005; Sanchez and Thomson 1997; Walzer 1998; Yavorsky et al. 2015), even when their relationship before the baby’s birth was relatively egalitarian (Calasanti and Bailey 1991; Shelton 2000). In families that equally share parenting, women often spearhead these arrangements (Deutsch 1999).
Research also finds that men’s and women’s attitudes toward mothering and the division of household labor change after the transition to parenthood, with their attitudes becoming less egalitarian, and becoming more likely to support the idea that mothering is women’s most important role (Baxter et al. 2015).

As changes happen in couples’ divisions of labor, the effects of parenthood are more evident in how they reshape women’s routines, rather than men’s (Baxter, Hewitt, and Haynes 2008; Blair and Lichter 1991; Cowan and Cowan 1992; Sanchez and Thomson 1997; South and Spitz 1994). Since the 1960s, time spent in domestic labor (except for childcare and shopping) has declined, which is mainly due to women’s decreased housework and increased labor force participation, later marriage, and fewer children. Men’s time spent doing housework has increased (Bianchi et al. 2000; Coltrane 2000; Yeung et al. 2001). However, women continue to do more household labor than men (Bianchi et al. 2000; Coltrane 2000; Craig and Mullan 2011; Gjerdingen and Center 2005), and the gender gap is widest among married couples (South and Spitze 1994). Although men and women are more likely to share household labor when they are both employed (Coltrane 2000), the transition to parenthood changes this, even among dual-earning couples. In a study among dual-earner couples who did approximately equal amounts of housework prior to having children, Yavorsky et al. (2015) found that after the birth of their first child, women did significantly more housework than men, supplementing their existing household labor with childcare, whereas men decreased the time they spent doing housework.

Research also finds that the division of household labor usually falls along gendered lines within heterosexual married couples, and that women take the majority of responsibility
for childcare (Bobel 2002). Current cultural assumptions and beliefs about motherhood often position responsibility as a core element of motherhood (Fox 2009; Hays 1996; McMahon 1995; Ruddick 1995). Within this division of labor, women and men take on manager and helper roles, respectively (Coltrane 1989). Coltrane defines managerial control as noticing when a household chore needs to be done, and making sure someone is adequately doing it. It also involves communicating with household members about timelines, supervising different schedules, making family plans, and meeting the demands of activities, such as making sure children bring their cleats to soccer practices (Alby et al. 2014). This management happens with household labor and childcare.

Helpers, by contrast, wait to be told what to do, when to do it, and how it should be done (Coltrane 1989). The helper does not carry the same responsibility for the household labor as the manager. Men are more likely to occupy the role of helper and women to occupy the role of manager in heterosexual married couples (Alby et al. 2014; Allen and Hawkins 1999; Blain 1994; Coltrane 1996, 2000; Craig 2006; Deutsch 1999; Ehrensaft 1987; Gerson 1993; Hays 1996; Mederer 1993; Rehel 2014). Even when men may desire to divide the household labor and childcare fairly and equitably, they do not assume responsibility for, anticipate, or plan activities, effectively continuing to play a helper role because they are not engaging in additional mental labor (Walzer 1998) that the manager roles demands (Coltrane 1989). Women may still carry the responsibility for household labor or tasks even as others complete the tasks (Alby et al. 2014; Daly 2002; Doucet 2001). Research also suggests that women have a hard time relinquishing control over household management (Allen and Hawkins 1999; Coltrane 1989; Ferree 1991; Hays 1996). As the household managers,
women are also likely to feel accountable to the dominant ideology of intensive mothering. I now turn to a discussion of intensive mothering and breastfeeding.

INTENSIVE MOTHERING

“Intensive mothering” is a concept that has been widely employed since the publication of Hays’s (1996) book The Cultural Contradictions of Motherhood. According to Hays, the ideology of intensive mothering is made up of “child-rearing methods that are child-centered, expert-guided, emotionally absorbing, labor-intensive, and financially expensive. And it is the individual mother who is ultimately held responsible for assuring that such methods are used” (122). This is the currently dominant ideology that prescribes U.S. childrearing practices, and is widely understood and commonly accepted (Hays 1996; see also Elliott, Powell, and Brenton 2013). While Hays focuses on mothering more broadly, I specifically apply intensive mothering to current breastfeeding beliefs and practices, as others have as well (Afflerback et al. 2013; Andrews and Knaak 2013; Avishai 2007; Faircloth 2013; Lee 2007, 2008; Murphy 1999, 2000; Stearns 2013). Next, I briefly discuss some of the ways that breastfeeding reflects the five above-mentioned characteristics of intensive mothering.

**Breastfeeding is Child-Centered**

Although medical research finds health benefits for women who breastfeed, such as lowered risk for breast cancer (Collaborative Group on Hormonal Factors in Breast Cancer 2002), the dominant breastfeeding discourse is child-centered. According to Hays (1996),
child-centered means sacrificing your needs as a parent and doing what you regard as best for the child. The actual time, labor, and energy required of mothers to breastfeed are downplayed or denied when breastfeeding is promoted as the healthiest thing for children (Carter 1995; Law 2000). Women are often rendered invisible as breastfeeding research touts the benefits for children (Wall 2001). This also applies to the pressure on women to pump when they go back to work, in order to do the best by continuing to provide breast milk for their baby (Avishai 2004). Mothers are expected to devote themselves wholeheartedly to their children in order to reduce potential risks to their children (Wolf 2010).

Breastfeeding is Expert-Guided

Historically, breastfeeding was associated with poor, immigrant, and unsophisticated mothers, but now it is a marker of privileged, informed motherhood (Avishai 2007). Beginning in late 1800s, women were expected to obtain expert advice from medical and public health practitioners regarding the best ways to raise their children (Apple 2006) which essentially medicalized and moralized motherhood (Lee 2007; Litt 2000). Researchers have found that women privilege, listen to, and try to comply with medical discourses when it comes to advice about breastfeeding (Andrews and Knaak 2013; Avishai 2007; Stearns 1999, 2013). The idea of breastfeeding as expert-guided is also evident in the ways the AAP’s guidelines are held as a standard for infant feeding, and how feeding practices are constructed in these medical accounts. Breastfeeding has become increasingly medicalized by emphasizing breast milk as nutritionally superior to formula, and is framed as especially
crucial to promoting infant health (Bartick and Reinhold 2010; Lupton 2011; Schmied and Lupton 2001).

Despite continued labeling of breastfeeding as natural, there has been a strong medicalization of infant feeding, that it must be taught through scientifically based, professional intervention (Carter 1995; Law 2000; Lee and Bristow 2009; Litt 2000; Wall 2001). The medical discourse has gained power, and parents feel accountable to medical experts, which can undermine mother’s confidence and can lead women (and others) to disregard experiential or embodied knowledge (Andrews and Knaak 2013). Responsible mothers are expected to select the proper advice, sifting through all that’s available to them, to make an educated decision (Apple 2006). Breastfeeding is additionally expert-guided as expectant parents are supposed to read through multiple books, magazines, classes, and meet with experts such as lactations consultants in order to learn about and comply with dominant breastfeeding and parenting discourses (Avishai 2007).

*Breastfeeding is Emotionally Absorbing and Labor-Intensive*

According to the ideology of intensive mothering, giving love is the foundation of good child rearing (Hays 1996). Breastfeeding promotion literature endorses mother-child bonding as one of the primary benefits of breastfeeding, and part of this is the love and nurturance that breastfeeding is said to provide. Additionally, breastfeeding is a time-consuming task, especially in the early weeks and months of an infant’s life. Given our current ideas about breastfeeding as something that only the birth mother can do, it cannot be shared with others (Stearns 2013).
Breastfeeding is Financially Expensive

Although many people tout the benefit that breastfeeding is free, this is often only in contrast with the cost of infant formula. The hidden costs of breastfeeding can also come from breastfeeding women’s lesser labor force participation (Rippeyoung and Noonan 2012). There are additional feeding accessories for new parents to purchase that go beyond the basic necessities marketed to pregnant women and babies (Avishai 2007) such as nursing pillows, stools, and chairs. Aside from the products some women may buy, breastfeeding is also not cost-free in terms of the time it takes and women’s exits or breaks from the labor force. Women who exclusively breastfeed for six months or more (which would be in accordance with the AAP’s guidelines) experience lower earnings from paid labor over time when compared with women who breastfeed for less than six months, and women who formula-feed their infants (Rippeyoung and Noonan 2012). If women follow the ideology of intensive mothering, they may be putting what they see as their child’s needs before their own, and in order to be a good mother, this means sacrificing paid employment for breastfeeding.

Overall, breastfeeding has become an essential practice of good mothering (Lupton 2000) and is thought to be in the baby’s best interest (Murphy 2000). Mothers who are able to exclusively breastfeed and intensively mother are thus thought of as “good mothers.” Yet as my findings reveal, the socially constructed dominant breastfeeding discourse can have real consequences, particularly for women who do not or cannot breastfeed, leading them to feel guilt or shame over their choices and actions. Notably, there is a recent trend of women pushing back against the “breast is best” ideology, particularly among women who have been
judged or stigmatized for not breastfeeding (Wilson 2017). While my participants for the most part continued to endorse the dominant breastfeeding discourse, their experiences with breastfeeding led them to make choices regarding infant feeding strategies which they determined to be best for their child. I now turn to a discussion of the organization of the dissertation.

ORGANIZATION OF THE DISSERTATION

Chapter two is an in-depth description of my research questions, sample of participants, and research method. I used longitudinal qualitative interviews with multiple family members, including separate and joint interviews (Hermanowicz 2013; Reczek 2014). I additionally explain my researcher positionality, bias, and ethical concerns as I undertook this research.

In chapter three, I examine how the dominant breastfeeding discourse reinforces the ideology of intensive mothering. I find four common reasons that participants gave for breastfeeding: it promotes mother-child bonding and it is healthy, free, and natural. These reasons reinforce the dominant view that breastfeeding should be pleasurable, natural, and easy for women to do, yet this was not always the case for my participants. Women who faced barriers to exclusive breastfeeding used their narratives to claim the good mother identity through how they talked about pushing through pain, determining and doing the best for baby, and working hard to breastfeed. Rather than challenge the dominant discourse and risk further shame and judgment for their infant feeding strategies, these mothers accounted for their feeding strategies by aligning themselves with intensive mothering (Hays 1996).
demonstrating ways they conformed to—rather than how they were deviating from—the dominant breastfeeding discourse.

Chapter four examines how participants framed bonding with their baby. I analyze how participants actively worked to include fathers in the breastfeeding bond. While efforts to include men may appear to reduce women’s childcare labor, my analysis reveals that these practices added to women’s invisible labor of childcare through the additional mental labor they did to include their husbands. I develop the concepts of *daddy worry* and developing *inclusion techniques* to illustrate the invisible emotion work women engage in prior to the baby’s birth as they worry about and make plans to include men in breastfeeding.

Additionally, families drew on their private resources to cope with their situations, which highlights the individualistic and privatized nature of caregiving. I argue that while some families worked to include outsiders in the breastfeeding bond, other families purposefully and strategically worked to keep others out, drawing symbolic boundaries around their nuclear family, a process I term *family gatekeeping*. Each of these practices also involved a great deal of emotion work for new parents, and mothers especially, as they faced the realities of becoming parents.

In chapter five, I examine the division of childcare labor that takes place at night. I bring together the literature on the gendered division of childcare labor—focusing on couples who adopted a manager-helper dynamic—with the sociology of sleep literature, especially as it applies to Venn and colleagues’ (2008) idea of the fourth shift of emotional and physical family care. I find that the manager-helper dynamic that other research has documented in heterosexual married households extends into the night as women take responsibility for the
emotional and practical needs of their family. Couples justify men’s lesser and women’s
great involvement in the nighttime care with explanations regarding the value of men’s paid
labor and biological inevitabilities (e.g., breastfeeding requires women’s bodies; men are
heavy sleepers). My research further contributes to the literature by revealing that even prior
to birth, couples make plans about who will get sleep, when, and how and that these (often
highly gendered) plans continue over time, even after women return to their paid jobs.

I conclude the dissertation with chapter six, where I discuss the main theoretical
contributions and practical implications of this research. First, I argue for the benefits of
studying routine family life in order to understand the processes that lead to unequal
divisions of labor within families. My longitudinal data reveal how patterns were established
early on, and the beliefs and practices that contributed to creating these patterns. Second, I
contribute to the existing literature on the manager-helper roles that married heterosexual
couples often adopt, demonstrating how this dynamic also carries into the fourth shift of
nighttime care work. I posit that women and men collaborate in constructing the manager-
helper roles, and that their adoption of childcare practices whereby women took
responsibility for childcare and men did not, led to unequal divisions of labor within families.
Third, my findings reveal the ways men consistently benefit from gendered beliefs and
practices within families. I conclude by arguing that the U.S. is lacking in family support
policies, particularly policies that support parents who care for children, and we would
benefit from implementing such supportive policies that recognize the work of caring.
CHAPTER 2
RESEARCH METHODS

INTRODUCTION

This chapter is devoted to explaining the research approach I took to this study. I conducted a longitudinal qualitative interview study, combining individual and joint interviews with new parents. I will begin this chapter by providing an overview of my guiding research questions. Next, I will discuss the participants, beginning with the recruitment process and then describing the sample demographics. Third, I will describe in detail the research methods and study design, followed by the data collection and data management. Fourth, I will discuss the data analysis. I will conclude this chapter by discussing my positionality as a researcher, including thoughts on bias, reflexivity, and ethical concerns.

RESEARCH QUESTIONS

My research was guided by one overarching research question: *How do first-time parents conceive of and experience breastfeeding over time?* Within this broad research question, I also explored the idea of support. I wanted to know what support meant to expectant and new parents, as individuals and couples, and how they experienced it, or wished they could have experience it. Breastfeeding is typically seen as a solitary act that only mothers can do (Stearns 2013). Yet recommendations for increasing breastfeeding rates often include the idea that women need to be supported by medical experts or partners, and
Breastfeeding is also often viewed as an individual’s choice, which is problematic in two ways. First, given the ideology of intensive mothering and the notion that “breast is best,” breastfeeding may not be so freely chosen. Second, framing breastfeeding as a choice falsely assumes that everyone has equal access to make that choice rather than recognizing the privileges associated with the rhetoric of choice. In light of these considerations, I asked, how do new parents who plan to breastfeed describe their intentions and decision-making processes around breastfeeding? What does breastfeeding (and other types of infant feeding) mean to them? What barriers do they face, and how do they overcome them (or not)? How do parents view themselves and one another as a result of their infant feeding practices?

Because I sought to discover meanings and patterns in how couples talked about expectations and experiences with breastfeeding, I took a qualitative approach to this study, and employed a complex research design. I conducted a qualitative longitudinal study that involved interviewing couples individually and jointly. Before I describe the methods, I will first discuss the recruitment process and sample demographics.

PARTICIPANTS

Recruitment

I began recruiting participants in the fall of 2013, after obtaining IRB approval. I emailed a short statement about my research to local friends within my social network, asking them to pass it along to any friends to whom it might apply. I created a flier with pull-off tabs that I posted in a local birthing center and local doctor’s offices. I also created a
digital flier that I posted (with permission) on several Facebook sites for breastfeeding support, such as The North Carolina Breastfeeding Coalition and the National Breastfeeding Support Group. I wrote a guest blog post and attended the kick-off event for The Breastfeeding Collaborative, a project aimed at promoting and supporting breastfeeding in religious congregations that serve low-income communities in Wake County. I contacted Equality NC and posted a digital flier on their Facebook group page, and sent out a description of my research to a variety of same-sex parent listservs. I posted an advertisement to Craigslist. I also asked each participant if they would be willing to pass along my information to others who might also want to participate. I recognize that with my statuses as a white, married, highly educated, heterosexual woman, I have limitations in my social network when it comes to accessing diverse groups of people. Although I tried to overcome these issues, I was not successful in recruiting any same-sex partners, non-white individuals, or lower-income families.

In total, 24 women contacted me about my research; half agreed to participate and half did not. Of the 12 who agreed to participate, some found out about the study through my social network contacts \((n = 6)\), some contacted me after seeing fliers posted on various Facebook group pages and doctors’ offices \((n = 4)\), and some were friends of other participants \((n = 2)\). The 12 other women who contacted me declined to participate for reasons including being too busy \((n = 4)\), their husband did not want to participate \((n = 2)\), or they never responded after I gave them more information about the study \((n = 3)\). The remaining three women did not participate due to ineligibility; for example, going into labor before we could set up our first interview or having a due date past the end of the data
collection. The 12 who did not participate found out about the study through my social network contacts (n = 2), fliers posted on Facebook groups or doctors’ offices (n = 5), or through another participant (n = 1). The rest did not tell me how they found out about the study (n = 4).

In order to participate, women had to be at least 13 weeks pregnant at time of recruitment. This signifies the start of the second trimester of pregnancy, which lowers the likelihood of miscarriage. For the most part, I interviewed women after they had entered the third trimester, past 28 weeks. My reasons for delaying interviews until the third trimester included that, as the due date approached, women increasingly experienced the physical intensity of pregnancy, and the body work of having a child became more apparent. Additionally, the non-pregnant partner may also experience the arrival of the baby as more “real” when it is imminent, and when they see the growing effects of pregnancy on their partner’s body. Secondly, as each pregnancy progressed, I thought it was more likely that couples would have thought about and discussed decisions around birth and breastfeeding. Additionally, couples who were planning to take a childbirth and/or breastfeeding class usually did so in the third trimester, so these types of preparations also may have prompted the soon-to-be parents to think or talk about breastfeeding. Qualitative interviews are richer and thus more valuable when participants have experiences with and/or knowledge of the topic of the interview (Charmaz 2006; Corbin and Strauss 2008; Kleinman 2007). Another key requirement for participating in this study was that this would be the first child for both parents. I wanted the experience of having a baby and breastfeeding to be novel for them because, as others discuss, parenting restructures one’s social world, and family dynamics
change with each additional member and over time (Coltrane 2000; LaRossa 1986). I was interested in the shift that takes place when the first child enters the family, and all the new experiences the families would face.

An additional requirement for couples to participate was that they be living together, whether married or not. This was important because one of the aims of this research was to study partner support as couples became parents. Decades of research document the significance of how married couples allocate their time in terms of paid labor, housework, and parenting (Bianchi et al. 2000; Coltrane 2000; Craig 2006; Craig and Powell 2011; Lam, McHale, and Crouter 2012; Lyonette and Crompton 2015; Milkie, Raley, and Bianchi 2009; South and Spitze 1994; Webber and Williams 2008; Yeung et al. 2001), noting significant differences and increased gender specialization of tasks in the transition to parenthood (Baxter et al. 2015; Baxter, Hewitt, and Haynes 2008; Gjerdingen and Center 2005; Raley, Bianchi, and Wang 2012; Rehel 2014; Sanchez and Thomson 1997; Yavorsky, Kamp Dush, and Schoppe-Sullivan 2015). People who live together must figure out how to manage the work of living together, including the mundane tasks of eating, doing laundry, and childcare (Bianchi et al. 2000). Finally, the couple had to be planning to breastfeed their baby, since this research is about breastfeeding expectations and experiences over time. However, if the mother ended up not being able to breastfeed or changed her mind, that did not disqualify families from participating. Breastfeeding, like birth, is unpredictable; therefore it was the intention of breastfeeding that I used as an indicator of the family’s ideology of feeding and parenting, whether or not they were able to follow through with their intentions. I was also
interested to discover how they followed through with their original intentions, and how they framed their infant feeding choices and practices.

Sample Demographics

The final sample consisted of 12 couples. This is a small sample size; however, given the research design (discussed in-depth below), this meant 24 individuals who were interviewed three times. For each couple in the study, there are five interviews (two individual, one joint). I conducted a total of 60 interviews.

I collected participants’ demographic information at the end of the first interview. I gave each participant a sheet of questions (see Appendix A), or asked the questions verbally if the interview was over video-chat. After the first few interviews, I added a question about how long the couple had been together, as well as how long they had been married. I later separated the “household income” question into individual incomes. Some couples wrote down different amounts for their household income. In these cases, I chose to include the higher of the two for Table 1. See Table 1 for Time 1 demographics.

Additionally, by the end of the study, many families experienced some type of change, such as some of the women quitting their jobs to stay home with their babies, amount of education obtained, occupation, and household income. Some changes occurred for families within their current jobs, some changed jobs, and some moved. Families where the woman quit her job often experienced a loss in household income. See Table 2 for Time 3 demographics.
## TABLE 1: Time 1 Interview Demographics

All participants are white and married

<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Married</th>
<th>Education</th>
<th>Emp. Status</th>
<th>Occupation</th>
<th>HH income</th>
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<td>2 years</td>
<td>Some college</td>
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<td>Esthetician</td>
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<tr>
<td>Robert</td>
<td>33</td>
<td></td>
<td>BA</td>
<td>FT</td>
<td>Insurance Agent</td>
<td></td>
</tr>
<tr>
<td>Robert</td>
<td>33</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Andrea</td>
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<td>7 years</td>
<td>MA</td>
<td>FT</td>
<td>College Instructor</td>
<td>$102,000.00</td>
</tr>
<tr>
<td>Josh</td>
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<td></td>
<td>BA</td>
<td>FT</td>
<td>Civil Engineer</td>
<td></td>
</tr>
<tr>
<td>Pat</td>
<td>34</td>
<td>2.5 years</td>
<td>PhD</td>
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</tr>
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</tr>
<tr>
<td>Shawn</td>
<td>27</td>
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<td>BA</td>
<td>FT</td>
<td>Project Manager</td>
<td></td>
</tr>
<tr>
<td>Desiree</td>
<td>35</td>
<td>7 years</td>
<td>PhD</td>
<td>PT</td>
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</tr>
<tr>
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<td></td>
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<td>FT</td>
<td>Actuary</td>
<td></td>
</tr>
<tr>
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<tr>
<td>Jill</td>
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<td>4 years</td>
<td>MS</td>
<td>FT student</td>
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</tr>
<tr>
<td>Rachel</td>
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<td>4 years</td>
<td>PhD</td>
<td>FT</td>
<td>Writer</td>
<td>$150,000.00</td>
</tr>
<tr>
<td>Nick</td>
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<td></td>
<td>BA</td>
<td>FT</td>
<td>Electrical Engineer</td>
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</tr>
</tbody>
</table>

+ = Had a specialist degree beyond MA

* = Lived off student loans
**TABLE 2: Time 3 Interview Demographics**

Changes from T1 indicated in **bold**

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<thead>
<tr>
<th>Name</th>
<th>Education</th>
<th>Emp. Status</th>
<th>Occupation</th>
<th>HH income</th>
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</thead>
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<td>Allie</td>
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<td>n/a</td>
<td>Stay at Home Mom</td>
<td>$40,000.00</td>
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<td>Robert</td>
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<tr>
<td>Andrea</td>
<td>MA</td>
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</tr>
<tr>
<td>Josh</td>
<td>BA</td>
<td>FT</td>
<td>Civil Engineer</td>
<td></td>
</tr>
<tr>
<td>Ashley</td>
<td>PhD</td>
<td>FT</td>
<td>Post-doc</td>
<td></td>
</tr>
<tr>
<td>Pat</td>
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<tr>
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<td>Shawn</td>
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<tr>
<td>Nick</td>
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<td>FT</td>
<td>Electrical Engineer</td>
<td></td>
</tr>
</tbody>
</table>

+ = Had a specialist degree beyond MA  
* = Experienced a promotion  
^ = Same job title but different job

Class location can be difficult to determine, and I did not ask participants directly what social class they believed they belonged to. I attempted to use Lareau’s (2003) approach, including employment, occupation, and education to assess participants’ social
class standing. For this study, I asked for each adult participant’s education, occupation, and employment status, as well as their own parents’ education and occupation. Following Lareau, I used the following to determine middle-class: “households in which at least one parent is employed in a position that either entails substantial managerial authority or that centrally draws upon highly complex educationally certified (i.e., college-level) skills” (2003: 279).

Looking at Table 1, all but one participant had graduated college. Nine participants held a bachelor’s degree, eight participants held a master’s degree, and six participants held a doctoral degree. For those couples where both partners had a bachelor’s degree or less, at least one of the partners did have some type of authority in their occupation. Therefore, I would classify these participants as at least middle class, although some of them may be more “lower” middle class, whereas the majority are “upper” middle class due to their high education statuses and high household incomes. Additionally, in considering the participants’ parents’ educational attainment, most of the parents were also highly educated (although not as much as their children). Twenty-five percent of participants’ mothers had less than a bachelor’s degree, and 38 percent of participants’ fathers had less than a bachelor’s degree. The majority of the parents’ occupations would be considered white-collar jobs, such as school administrator, lawyer, and manager.

The fact that the participants were all white, married, and middle-class may reflect my social network but also reflects some larger patterns in breastfeeding. White, highly educated women are more likely to breastfeed (Gibson-Davis and Brooks-Gunn 2007; Guzzo and Lee 2008). Nonwhite and low-income women are less likely to breastfeed, which may
also correlate with their economic need to return to a job that is less likely to afford them the option to pump on a regular basis (Galtry 2000). Additionally, women in jobs that are more highly skilled are also more likely to have easier access to lactation support after returning to work, such as a private office or space to pump, increased job autonomy to schedule pumping, and more time off work for maternity leave, which increases the likelihood of sustained breastfeeding (Avishai 2004; Roe et al. 1999).

Due in part to their middle-class status, these families—especially the mothers—were more likely to accept intensive mothering practices as the norm in their social circles. They also experienced the “cultural contradictions” of motherhood (Hays 1996) because of their pre-baby education and career statuses. Due to their self-proclaimed commitments to breastfeeding along with their labor force commitments and their supposedly easier access to lactation support, these women appeared to be in a prime position to establish exclusive breastfeeding and succeed at continued breastfeeding after returning to work. As Avishai (2004) indicates, privileged women are best positioned to compensate for the obstacles that could hinder them from breastfeeding/pumping at work. Yet, there are many complicating factors when it comes to combining the work of breastfeeding with the work of the paid labor market. For example, Molly, a teacher, and Desiree, a counselor, found that in their professions there was little time for pumping, despite the supportive environments of their jobs.

In the next section, I provide an in-depth description of the research methods and study design, including details about each wave of data collection, in order to provide a comprehensive picture of the overall study.
RESEARCH METHODS AND STUDY DESIGN

Grounded Theory

For this project, I used grounded theory methods, following Charmaz’s (2006) description that “grounded theory methods consist of systematic, yet flexible guidelines for collecting and analyzing qualitative data to construct theories ‘grounded’ in the data themselves” (2). In a grounded theory approach, there is fluidity between data and theory, where data analysis guides further data collection. Qualitative researchers focus on how people account for their actions and experiences, and analyze data to develop an interpretation of the topic at work in the social world (Corbin and Strauss 2008). Corbin explains how external events exist; however, each event is filtered through multiple viewpoints that rarely reach consensus. Research participants create stories as they try to make sense of the events they experience, and as researchers we construct concepts and theories from these stories. It is out of these multiple constructions that we create knowledge (Corbin and Strauss 2008).

Longitudinal Qualitative Multi Family Member Interviews

For this study, I focused mainly on data gathered from a series of in-depth interviews with each family. Although “all is data” (Glaser 2002), and the experience of conducting in-depth interviews also allowed for some observation of the participants, the analysis is mostly based on the information participants gave during interviews as well as my email correspondence with participants. In-depth interviews offer a way to capture a full range of meanings, beliefs, and ideas that people hold about a certain topic. Follow-up questions can
be used to explore ambiguities, fill in blanks, and probe for meanings and feelings, and interviews may end up taking a different direction when the researcher follows up on the participants’ explanations, experiences, and contradictions in their accounts.

The research design involved longitudinal interviews with multiple family members, employing both individual and joint couple interviews. Although longitudinal research is often associated with extensive quantitative studies, the last few years has seen an increase in use of longitudinal qualitative data. Hermanowicz (2013) describes longitudinal research as “research in which (1) data are collected about an item over two or more distinct periods of time; (2) that which is analyzed is the same or comparable across periods of time; and (3) analysis involves comparison of data across time periods” (189). Thus, when we use qualitative research techniques in these ways, we may consider them longitudinal qualitative research (LQR). I used the longitudinal qualitative interview (LQI) technique.

Although LQR is fairly new, numerous sociology studies already have taken this approach. One method has been to use secondary data: qualitative portions of larger datasets (for examples, see Ashwin and Isupova 2014; Clark 2012; Coburn, Mata, and Choi 2013; Scott, London, and Gross 2007). Other researchers have followed individuals over a period of time (for examples, see Opsal 2012; Ovink 2014; Shirani 2013). My research design involved the latter, following a set of individuals over time. I recruited first-time parents before the birth of their child, and interviewed them at three distinct time points: before the birth of their baby (Time 1), two to seven weeks after the birth of their baby (Time 2), and six months after the birth of their baby (Time 3). I conducted a final follow-up open-ended survey when the child reached his or her first birthday (Time 4).
Before further description of the four waves of data collection, I will describe the second key aspect of the research design: the multi family member interview (Reczek 2014). Reczek defines the three most common types of multi family member methods: separate interviews with multiple family members, dyadic or group interviews with family members, or a combination of separate and dyadic interviews. I used a combination of the LQI and multi family member interview approach, interviewing each member of the couple individually at Time 1, individually again at Time 2, and then jointly at Time 3.

Conducting individual interviews with multiple family members is constructive for obtaining “partial truths and fissures” (Reczek 2014: 322), sensitive information that individuals might not otherwise share if another person was present, and independent accounts of joint experiences. In the Time 1 and Time 2 interviews, I interviewed couples sequentially (except in three cases) which allowed me to maintain consistency in the questions I asked, and established and nourished a relationship with each participant. One advantage of sequential interviews was that I was able to link information learned in a first interview to questions in a second interview, as long as I maintained confidentiality (Reczek 2014). Conducting back-to-back sequential interviews with one interviewer also did not allow spouses time between interviews to discuss the questions asked. However, when both spouses were in the same location (like a home), I was concerned about their privacy and willingness to talk candidly about their partner. To address this concern in these types of situations, I left it up to the participants to choose the location of the interview within their home, based on their comfort level, knowledge of their home’s layout, and whether or not their partner could overhear.
In addition to interviewing couples separately for the first two interviews, I interviewed each couple jointly at the final interview. Dyadic or group interviews with multiple family members are another way to see how families co-create and co-construct their reality in a collaborative way (Reczek 2014). Not only does this allow for verbal data, but observational data as well. I observed how couples interacted with one another, who answered questions first, who talked more, and if and how individuals interrupted each other. Additionally, because I had already interviewed each participant twice individually, I had a sense of their personalities and crafted my questions as well as my presentation of self in a way that would allow and encourage both individuals to answer questions. Sometimes I had to purposely direct a question to one participant. Other times I directed questions to both members to see who answered first. This allowed me to observe power dynamics in a family (Reczek 2014).

Studies that use a combined approach such as I did—conducting individual and dyadic/group interviews with multiple family members—can offer a more holistic view on family life (Reczek 2014). Talking with participants one-on-one may illuminate how they see themselves and their relationships, and then allows the researcher to observe the couple’s interaction during the dyadic interview. Additionally, when this method is employed, data from prior interviews can be used to facilitate later discussions. Reczek (2014) states that combining these approaches, as few have done in family studies, provides a “gold standard for scholars who want to gain a full view of family dynamics” (331).

Choosing any research method should be based on the researcher’s epistemology and research questions. My epistemology rests largely with social constructionism and symbolic
interactionism (Blumer 1969; Charmaz 2006). My goal in interviewing both members of the couple—not just the mothers but also their intimate partners—was to understand how they create and recreate meanings of breastfeeding. As a critical researcher and inequality scholar, I am also interested in power dynamics of the intimate relationship and how power and inequality come into play in people’s talk about and experiences of breastfeeding.

As stated above, the study consisted of four waves of data collection: in-depth interviews conducted at three distinct time-points and one follow-up questionnaire. In the first wave (Time 1), I interviewed couples before the birth of their child, when the pregnant partner was between 26 to 39 weeks pregnant.¹ These interviews were done individually and sequentially when possible. At Time 1, I asked questions about their ideas about breastfeeding, what they thought it will be like, why they were choosing to breastfeed, and what they thought breastfeeding would mean for their relationships with each other and with the baby (see Appendix A for complete interview guides). Many of these questions asked about hypothetical issues, which brought up an interesting issue of potentially asking questions that the couple had yet to think or talk about. For example, when I asked how they thought nighttime feedings would go, some participants had no answer. A few participants revealed in later interviews that our first interview sparked new breastfeeding conversations between the couple. This is an example of how the interviewer may influence a participant, especially when there are going to be multiple interviews taking place. I was sensitive to this

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¹ As I described in my recruitment section, participants needed to be at least in their second trimester of pregnancy to participate in the study. Pregnancies that have gone into the second trimester are more viable than those that have not. The first trimester of pregnancy lasts from one to 12 weeks, the second trimester is from 13 to 27 weeks, and the third trimester is from 28 weeks to the birth of the baby, which generally occurs between 37 to 42 weeks.
issue of introducing new ideas that the couple was previously unaware of or had yet to discuss. However, I learned from the way the participants reacted to me, the questions I asked, and the new issues and questions that arose through their participation in the study.

A key part of the first interview was to establish a relationship between myself (the interviewer) and the participants. Researchers risk losing access to their participants if they do not create rapport (Charmaz 2006). I interviewed first-time parents at a significant, highly emotional, and financially taxing point in their lives. I did not take it lightly that these families allowed me to be a part of this time, even in a small way. The rapport I created with them during the first interview was crucial because I interviewed them again after their baby was born and kept in touch with them until their baby was six months old. I took up time that they could have used to eat, sleep, work, or shower. This does not mean that the questions at the first interview were less intense or less important, but it does mean that my presentation of self and the relationship we created mattered greatly for their continued participation in the study. I wanted each person to have a positive first experience so that they were willing to be interviewed again.

In the second wave (Time 2), I again interviewed couples individually and sequentially. Although my original intent was to conduct the interview when the baby was between two to four weeks old, due to the reality of having a baby—such as babies who were born much earlier than their due dates, and scheduling around visiting family members—the babies’ ages at the Time 2 interview ranged from two to seven weeks old. At this time point, I brought the family a meal of their choosing, which was the only tangible benefit they received for participating in the study. In this interview, I wanted to know how things were
going. How was the birth? How was breastfeeding initiation? What do feedings look like? What do both partners do? Breastfeeding can be challenging, and many women stop breastfeeding within the first few weeks. My research question asked how couples experienced breastfeeding, and part of that concerned their experiences of support. I asked them if and how they felt supported, and where that support came from.

In the third wave (Time 3), I interviewed couples jointly, about six months after the baby was born. The babies’ ages at this interview ranged from six to seven and a half months old, due to scheduling difficulties, illness, and my own second pregnancy. I wanted to know what happened in the past six months: Did the mother keep breastfeeding? What about bottle-feeding? How did the partner participate? What changed in term of work and family life? I chose this time point because I thought that women who intended to breastfeed would most likely be aware of the expert advice from the AAP, which recommends exclusive breastfeeding for at least six months, and might want to breastfeed for the amount of time suggested by the experts. I also anticipated that by this time, the family might be experiencing breastfeeding in a significantly different way than at Time 2, such as negotiating paid labor and breastfeeding.

In the fourth wave (Time 4), when the baby was one year old, I sent participants an online questionnaire containing four open-ended questions about the issue of support, continued breastfeeding, ideas about parenting, and experiences with paid labor. Although this was not a part of the original study design, in a grounded theory approach, data analysis guides further data collection. As I was finishing the third interviews with some couples and
beginning the first interviews with other couples, I was memoing and coding interview and thought of more issues I wanted to follow up on.

A unique feature of longitudinal qualitative interviews is that the researcher has the opportunity to follow participants during a specific period of life. However, a potential problem with this method is attrition of participants, which was especially concerning with a small sample. Hermanowicz (2013) suggests that researchers should take care to establish strong rapport with participants as well as think about how to follow up with participants. This is done not only in interviews, but in written correspondences as well. For example, Lareau (2003, 2011) sent Christmas cards containing a five-dollar bill to each of the children in her study because she wanted to follow up with them as young adults a decade after her initial data collection. Managing the developing relationship may preserve and deepen the relationships between the participants and researcher. Through these relationships, detailed and meaningful data can be acquired. Hermanowicz (2013: 202) states: “Participant-researcher relationships developed over time enable a sharing of more private and detailed accounts than many initial interviews are able to obtain. LQR can thus enhance the validity in representations and explanations of the social world, if and only if subject attrition is offset by retention.” Through email exchanges with families throughout their participation in the study, bringing them a meal at the Time 2 interview, and engaging in conversations with them about their children as well as my research, I believe I developed strong rapport with each individual in my efforts to prevent any attrition from happening. All 24 participants (12 couples) that I recruited for the study participated through the Time 3 interviews, and only one couple did not respond to the Time 4 follow-up questionnaire.
Data Collection

Overall, the data collection spanned two and a half years, beginning with the first interviews in the fall of 2013 and concluding with the final one-year follow up questionnaires in the spring of 2016. At the end of each Time 1 interview, I asked participants if I could keep in touch with them through email. All the participants agreed that I could send them monthly check-in emails, although one husband did not want to give his email address and asked if I could just send emails to his wife. One family had a joint email account. I made it clear to the participants that the information they shared with me over email became part of the data. On average, I remained connected to each family through monthly emails and interviews for eight months. This does not include the final follow-up email and questionnaire, which took place when the baby turned one year old. I did not stay in touch with the participants between the third interview and the one-year follow up.

For the Time 1 interviews, I left the location up to the participants. Seven out of 12 couples chose to meet in a public location, and one couple invited me to their home for the first interview. I conducted eight Time 1 interviews (four couples) via FaceTime or Skype. Two couples lived too far away for me to interview them in person. Another virtual interview took place close to the birth of my second child, and we were trying to complete the interview before I went into labor. The final virtual interview took place just two weeks after the birth of my second child, when it was difficult for me to conduct it in person. Although the video-chat was less personal than being together, it was more personal than the telephone (Deakin and Wakefield 2014). Most of the Time 1 interviews were conducted back-to-back, except in three cases where the couple’s schedule did not permit it. In those
cases, the second partner’s interview was scheduled as soon as possible, following the first. I left the order of interviewing up to the participants. For the most part, the woman went first at both the Time 1 and Time 2 interviews, however, four men went first at Time 1 and three men went first at Time 2. Ironically, it was Dave, Jason, and Ed who went first at both interviews (Michael went first at Time 1 and second at Time 2). Although I did not question participants as to their choices of who should be interviewed first, I observed that my patterns of communication with the participants was consistently gendered as women took charge of scheduling and decision-making around the couples’ participation in the study. The women were the ones who contacted me about participating in the study, communicated with me about scheduling the interviews (with some exceptions), and responded to my follow-up emails. This is consistent with other research that demonstrates that women are typically managers of the home (Allen and Hawkins 1999; Coltrane 1996, 2000; Deutsch 1999; Ferree 1991; Hays 1996; Hochschild 1989).

Time 1 interviews averaged 30 minutes in length, excluding the time it took for me to collect demographic data. One reason I believe that these interviews were shorter was because some of the questions were about unfamiliar scenarios. For example, participants who gave brief answers—or didn’t have an answer—to the question of, “What are your plans for nighttime feedings?” gave much lengthier answers to, “What are your plans for working after the baby is born?” As indicated in Table 3, the Time 1 interviews were the shortest interviews, and the men’s interviews were, on average, shorter than the women’s interviews even though I asked them almost identical questions.
**TABLE 3: Interview Lengths in Minutes**

<table>
<thead>
<tr>
<th></th>
<th>Total Average</th>
<th>Total Range</th>
<th>Women's Average</th>
<th>Women's Range</th>
<th>Men's Average</th>
<th>Men's Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time 1</td>
<td>30</td>
<td>15-45</td>
<td>35</td>
<td>22-45</td>
<td>26</td>
<td>15-38</td>
</tr>
<tr>
<td>Time 2</td>
<td>54</td>
<td>26-90</td>
<td>61</td>
<td>33-90</td>
<td>47</td>
<td>26-69</td>
</tr>
<tr>
<td>Time 3</td>
<td>97</td>
<td>73-121</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
</tbody>
</table>

Because due dates are only an estimate, I told couples that I would contact them via their preferred method (phone, email, or text) two weeks after their baby’s due date.

Although I ideally wanted to interview the families when their baby was just two to four weeks old, due to the time lag between when I found out certain babies were born and scheduling difficulties, the babies’ ages at the Time 2 interviews ranged from two to seven weeks old. For the Time 2 interview, I interviewed 10 of the couples in their own homes. I conducted four interviews (with two couples) over FaceTime, and in these cases the couple was in their home and I was in a private office. In every case, I interviewed each member of the couple sequentially and allowed the couple to decide the order of the interviews. In most cases, both partners were home during the interviews, but in three cases the father was at work when I arrived, and came home while I was conducting the interview with the mother. The baby usually stayed with the person who was not being interviewed. Time 2 interviews averaged just under one hour in length. At the end of the interviews, I thanked the couple for allowing me to be a part of this time in their lives. I asked couples if I could email them once per month until our next interviews, just to keep in touch.
In the months between the Time 2 and Time 3 interviews, I emailed couples once a month, asking how they were doing and if there was anything they want to share. In some cases, I asked a specific follow-up question from an issue they had brought up previously (only in cases where this would not break confidentiality). I assured them that they did not need to email me back if they do not want to. In the cases where I had both partners’ email addresses \( n = 10 \) couples), I sent one email to both accounts. For the most part, the mothers responded with something on their mind, or a recent story of something that had happened. None of the fathers responded to these emails, however, one couple allowed me to use their family blog as data, and the husband was the one who wrote and maintained the blog.

The Time 3 interview was different because it was a joint interview with both partners, often with their baby present. In every case but two, I went to their home, usually at night or on a weekend. Two of these interviews were done via video-chat due to distance. I sat with couples at dining room tables or on living room couches, and was often joined by the baby and family pets. Time 3 interviews lasted on average one hour and 37 minutes. The joint interview also gave me the opportunity to observe the couple’s dynamics, including body language, interactions, correcting one another, and co-creating accounts.

Data Management

Sources of data for this project included in-depth interviews conducted by me, as well as email correspondence between myself and the participants. The first time I met with participants, I discussed the IRB consent form and had each participant sign the form and retain a copy for their records. I also asked each participant if they consented to be audio
recorded. At the end of the interview, I gave them a sheet of paper with demographic questions. Their actual name was not connected to this sheet. Once the interview was complete, I transferred the audio file onto my office computer and deleted it from the audio recorder. Interviews were transcribed by myself \((n = 16)\), research assistants \((n = 19)\), or a professional transcription company \((n = 25)\). No one else had access to these files. After each transcription was complete, I reviewed it to check for mistakes. Once an interview was fully transcribed, the audio file was permanently deleted from the computer. All identifying information in the transcription was changed. Pseudonyms were assigned to all participants. Additionally, the demographic information provided on paper was recorded on the computer, using only the participant’s pseudonym.

Since this was a longitudinal study, I needed to keep the participants’ real identity and contact information until the end of the study. I kept this information in a password-protected file, in a physical location separate from the rest of the data. At the end of the study, all identifying documents or files were deleted or destroyed. As for data collected by email, I copied and pasted emails into Word documents, and changed all identifying information so that they could not be linked back to the sender. I then deleted all the messages from my email.

At the end of the Time 3 interview, I asked for updated demographic information. Several couples experienced work transitions, either going from paid employment to staying at home or changing jobs (see Table 2). This also caused a change in household income. Other couples moved during the study, but stayed in touch using email and video-chatting.
DATA ANALYSIS

Data analysis was an ongoing activity during the course of the research. I memoed after each interview, writing down themes and concepts that stood out to me or that participants discussed as important during their interview. This allowed me to make connections between interviews, across individuals and across time. I began drawing a concept map, connecting concepts and ideas as they emerged during interviews and memos. I transcribed the interviews as soon as possible. Transcribing and reviewing interviews repeatedly allowed me to memo on the data and note important concepts and themes. This also facilitated further development with the interview guides, both helping me create new follow-up questions for the Time 2 and Time 3 interviews, as well as add questions to the Time 1 interviews on issues that came up in several of the first Time 1 interviews.

To code the data, I used ATLAS.ti, a qualitative data analysis tool. I went through many rounds of line-by-line coding, attempting to name each piece of data (Charmaz 2006). This process was neither seamless nor linear. I often returned to my memos and concept map as I developed broader, more theoretical concepts, and then I began coding again. For example, I coded instances where participants talked about their anticipated and experienced relationship with their baby, and which included codes such as “including others in the bond,” “excluding others,” “using other human milk,” “letting others feed,” and “bonding as a reason to breastfeed.” I wrote extensive memos on these codes and began to see how the codes were interrelated. I developed analytic categories based on the coding and memoing process. These codes coalesced into the concept of “bonding with baby,” as I found that in their narratives, participants framed bonding with their child through feeding practices as a
particularly special activity. As I examined the other main concepts that emerged from the data, I began to see how they were all tied to a larger theoretical category of doing the best for baby.

RESEARCHER POSITIONALITY: BIAS, REFLEXIVITY, AND ETHICAL CONCERNS

I thought a lot about my position as a researcher before and during the data collection. I held a somewhat insider status as a fellow new parent. My first child was 14 months old when I began interviewing, and I breastfed her until she was two years old. I also became pregnant with my second child during the data collection, and I continued conducting interviews throughout my pregnancy and after her birth. I acknowledge that I am biased about breastfeeding. As Kleinman and Kolb (2011) state, we can never be free of our biases, and we should not pretend to be. Therefore, in order to be more transparent, I tried to acknowledge my biases and beliefs about breastfeeding in my memoing and writing. I believe breastfeeding is in the child’s best interest. I believe it is healthy for the baby and the mother, and I believe in breastfeeding for as long as possible. However, I also had a very positive experience with breastfeeding both of my children. I never faced many of the negative issues that some of the participants did, such as low milk supply, bad latch, or mastitis. For the most part, breastfeeding was a physically, mentally, and emotionally positive experience for me even though it consumed a lot of my time. I took about nine months off from my graduate studies with my first child, and about six months off with my second, and both times I returned to work part-time for a few months before returning full-time. I acknowledge that many families do not have this option. If I had gone back to school
or work after six weeks, or even twelve weeks, my breastfeeding experience would have looked very different and I am certain I would have felt differently about it as well.

At times during data collection and analysis, it was challenging for me to separate my own feelings about breastfeeding from my findings. Charmaz (2006) warns us against forcing our own preconceptions on our data, and sometimes this was challenging for me. Although a few participants asked me for advice and questioned me about breastfeeding, especially during the Time 1 and Time 2 interviews, I responded carefully and deliberately. I tried to be vaguely encouraging to them as people who were facing new and unexpected challenges. Over time, conversations with my participants flowed easily, but I tried to remain somewhat guarded. I recognized that sharing too much of my own experiences might be problematic for how the participants came to view me and what they chose to share with me. For example, in each interview I asked participants how long they planned to breastfeed. Although they all knew that I was a mother, and some of them knew I had breastfed, most of them did not know that I had breastfed for two years, and some of them made negative comments about women who continued breastfeeding after a child could walk or talk. They may not have shared these ideas so freely if they knew more about my own breastfeeding practices.

I also found it challenging to meet people with whom I share things—like a new parent status, education, personal beliefs, and breastfeeding philosophy—and not create a friendship with them. This was especially true given the amount of time I spent talking or emailing with them. I genuinely liked all the participants, and wished I could have maintained an ongoing friendship with many of them. For the purpose of this research, I did
not believe in being a far-removed authority figure as an interviewer. All of the participants knew going into the study that I was a graduate student working on my PhD research. Because I met all of them in person or via video-chat, they all knew that I was a white woman. I am short and appear younger than I am, and had I not purposely revealed my parental status, they may have assumed I had no children. I believe that in this case, revealing my parent status gave me credibility with my participants. Additionally, during research, I became pregnant with my second child, and my pregnancy was visible in several interviews. I also continued conducting interviews after the birth of my baby, and both of these circumstances brought up some interesting questions and comments from the participants. I do not know if the things they learned about me made them trust me more or less. I hope that they became more comfortable talking with me over time. My data do suggest that I was at least somewhat successful at encouraging participants to open up to me. I hope that they enjoyed participating—many of them told me they did—because I certainly valued their participation, time, energy, emotions, and stories. I hope my dissertation does their narratives justice without ignoring the complexities or the inequalities that their practices revealed.

Also during the course of the research, I faced two ethical issues. First, as in any study, confidentiality is of the utmost importance. As described in the data collection and management section, I took pains to disconnect any identifying information that I used in reports from the actual people I interviewed. However, this led me to the issue of confidentiality between spouses. I was easily able to maintain confidentiality from the first two individual interviews, and I reminded them in the third interview that I would not bring
up anything they had told me before. However, my biggest concern remains that if my participants read my dissertation or any other publications from these data, they will most likely be able to recognize themselves, and therefore their spouse. For the data to make sense, I needed to identify who is partnered with whom in my reports. If the participant can recall a specific phrase or idea they shared, then they will also be able to figure out who their partner is, and read any quotes that I provided from their partner. By doing this, participants may learn something upsetting that their partner said, which could cause strain in their relationship. Reczek (2014) states that this issue is particularly relevant for this methodology, but does not offer any suggestions for how to deal with it. While I was frustrated by the lack of answers I found to solve this dilemma, after much thought, I reached the conclusion that there is no easy solution to this concern. One way I decided to manage this dilemma was to refrain from attaching the participant’s pseudonym to potentially harmful accounts so that if the participants read the reports, they will not know who made the statement.

The second ethical concern in this study involved minimizing emotional risk. There were no clear risks for participating in this study, however, pregnancy, childbirth, breastfeeding, and parenting can be highly emotional topics, especially when an event does not go as planned. I wanted participants to feel comfortable during the interviews because in addition to the topics mentioned above, we also sometimes talked about fears, anxieties, religious beliefs, and sex. I reminded participants that if my questions caused them strong emotional reactions, we could always stop or pause an interview. Although the interview process did bring out some strong emotions in a few participants, no one asked to pause or
stop. Additionally, many participants expressed how much of a relief it was to share their experiences, both the good and the bad, without having someone give them advice or trying to fix their problems. It was critical for me to recognize and be sensitive to the challenges that the couples faced, both in how I interacted with them and in how I worded my emails. I did not want to assume that things were going well, or even that they were happy with life and parenting. For example, when I checked in with one mother about a month after our second interview, she responded that she and her husband were experiencing conflict, and that she was feeling stressed and hurt because of this. She also attributed a dramatic drop in her milk supply to this conflict. I was glad she felt comfortable sharing this with me, and I tried to remain sensitive to others who might be experiencing similar situations.

In order to minimize emotional risk to the participants, I did several things. First was the reminder about stopping or taking a break during the interview. Second, I included fewer sensitive questions at the first interview. By the second and third interviews, I felt more comfortable asking challenging questions, especially when it came to emotionally-charged situations for the new parents. The participants also appeared more comfortable opening up to me at this point. Perhaps it was also reassuring to them that we were in a private space in the comfort of their own home. Although I recognize that each account was the participant’s story and not necessarily the Truth, my observations were usually that participants were more comfortable and open with me in the second and third interviews.
CHAPTER 3

BREASTFEEDING AND THE GOOD MOTHER IDENTITY

I was not prepared for how difficult breastfeeding would be and all the trials that I was going to face. I just thought I was going to be naturally equipped for it 'cause everybody told me, “It’s just so natural and wonderful and easy.” Like, no, it’s not. It’s not. It’s hard. It’s really hard. And it’s not natural. – Allie, second interview

INTRODUCTION

Throughout my interviews, I found that the parents I met discussed the lengths they took to become good parents, particularly in terms of their infant feeding choices and strategies. While nearly half of the participants expressed their desire to follow the dictum “breast is best” at their antenatal interviews, their breastfeeding experiences, situations, and feelings all contributed to their individual definitions and solutions of what it meant to do the best for their baby. Yet, despite their infant feeding strategies which individuals claimed to be the best for their particular child, participants continued to acknowledge the moral dimensions of the dominant breastfeeding discourse. Women, especially, even prior to the birth of the baby, recognized how their identities would be tied to motherhood and that they would be held accountable for their feeding strategies. They made it clear that not achieving the exclusive breastfeeding standard impaired their identities as good mothers.

Men’s identities, however, did not hinge on caregiving or breastfeeding the ways women’s did. Chris discussed in his third interview that he was not even thinking about how the choices he and his wife made regarding infant feeding reflected on his paternal identity:

I would say as far as my identity, I don’t think feeding him or how we feed him, that’s not even really on my radar of things that I really think about…. The fact that
[the baby] is not breastfed, I don’t think it has impacted that at all. And usually when people talk to you as a new dad, nobody even asks about that. I mean, I think they do it more with the moms for sure, but with the dad it’s always other types of things people ask about.

In contrast to men’s narratives, women were constantly thinking about the types of mothers they were, how they could potentially be judged by others for their parenting successes or failures, how they compared with other women, and the ways they felt accountable for their feeding decisions. As Allie’s opening quote illustrates, the dominant breastfeeding discourse positions women’s bodies as naturally able to breastfeed. Because expert advice endorses breastfeeding as the healthiest feeding option for babies, women risk being labeled bad mothers if they do not breastfeed.

In this chapter, I first review literature examining how breastfeeding and the good mother identity are connected to doing what is best for the baby. Second, I analyze the four answers that participants commonly gave for why they chose to breastfeed, and I connect these ideas to the dominant breastfeeding discourse and intensive mothering. Third, I focus on women who faced barriers to exclusive breastfeeding. These women provide accounts for their feeding decisions and strategies that—rather than challenge the dominant breastfeeding discourse that “breast is best”—align their practices with the dominant discourse, thereby allowing them to claim the good mother identity. I conclude with the implications of these findings for parents, especially mothers, when they try to do their “best” in terms of infant care, yet remain accountable for their feeding decisions.
BREASTFEEDING, THE GOOD MOTHER, AND DOING THE BEST FOR BABY

Exclusive breastfeeding reflects the ideology of intensive mothering because, as I described in chapter one, it is child-centered, expert-guided, emotionally absorbing, labor-intensive, and financially expensive, and mothers are held ultimately responsible for the health and wellbeing of their children (Hays 1996). Mothers are expected to meet high standards in order to be considered “good mothers,” and exclusive breastfeeding has become a moral obligation for mothers (Lee 2007; Murphy 1999; Wall 2001). As Murphy states, “The injunction to breastfeed is one more way in which the ‘good mother’ is constructed and promulgated in and through the medico-scientific literature” (2000: 295). Even prior to the birth of a baby, women begin to internalize the ideology of intensive mothering and what it means to be a good mother (Bass 2015; Waggoner 2015). This was the case among my participants. For example, Ashley said at the first interview, “I think it kind of feels like you’re—I mean, not that if you don’t breastfeed you’re not a real mom—but I just, I feel like they’re kind of connected in my head, you know, it’s like, that’s what you do, that’s what people have done for ages” (laughs).

Part of the pressure mothers feel to breastfeed comes from the cultural associations between breastfeeding and good mothering (Avishai 2007; Knaak 2010; Lupton 2000; Marshall et al. 2007; Murphy 1999, 2000; Ryan et al. 2010; Stearns 2009). In addition, the

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2 This point is somewhat contradictory in terms of participants’ narratives versus research findings. Many of my participants said that breastfeeding was free, in comparison to infant formula. For example, when Molly stopped breastfeeding her son at six months, she said she would have thought about continuing breastfeeding if she had realized the high cost of formula. However, researchers analyze breastfeeding as costly in terms of the loss of women’s income from time taken off work or reduced hours (Rippeyoung and Noonan 2012), or all the extra breastfeeding accessories consumers are encouraged to purchase (Avishai 2007).
“breast is best” discourse conveys a medicalized imperative to breastfeed as the best way to foster infants’ health and development and reduce risks (Lupton 2011). Medical research emphasizes the long-term benefits associated with breastfeeding, such as lowered risks of obesity (Weden, Brownell, and Rendall 2012), developing asthma (Oddy 2004), Type I diabetes (Young et al. 2002), and childhood cancer (Martin et al. 2005). The medical and public health promotion of breastfeeding sends powerful messages to women about what it means to be a good mother (Lee 2007). It conveys the idea that mothers are held ultimately responsible for their children’s short- and long-term outcomes (Hays 1996) through their feeding practices. When mothers do not maximize positive outcomes and minimize risks for their children, they are vulnerable to criticism from others (Murphy 2000). Part of the ideology of intensive mothering is that it is expert-guided (Hays 1996), but mothers are also expected to sift through the available information and select the best option for their child (Apple 2006). Responsible mothers minimize health risks to their babies by making informed choices (Lee 2007). These informed choices involve using medical information about the superiority of breastfeeding to guide feeding choices (Knaak 2010; Stearns 2013; Wolf 2010).

Because breastfeeding has come to symbolize good mothering (Murphy 2000; Stearns 1999; Wall 2001), research documents how mothers who formula feed use strategies to retain, regain, or realign their identities as good mothers (Lee 2007; Murphy 2000). Women who do not breastfeed or face barriers to breastfeeding feel as though they have failed at a fundamental aspect of mothering (Avishai 2007; Blum 1999; Braimoh and Davies 2014; Knaak 2006; Simonardottir 2016; Taylor and Wallace 2012), and often articulate their
inability to conform to notions of the “good mother” identity (Knaak 2010; Lee 2007; Murphy 1999, 2000, 2003; Schmied and Lupton 2001). Additionally, non-breastfeeding mothers risk being labeled deviant by others (Faircloth 2013; Hausman 2007; Tomori, Palmquist, and Dowling 2016) and must account for their feeding practices in ways that refute the deviant label (Wall 2001).

In short, the dominant breastfeeding discourse focuses on individual mothers, lays blame on mothers for any negative outcomes that befall their children and ignores social structures that also affect children’s outcomes. Yet some research concludes that the advantages often attributed to breastfeeding are also outcomes linked to higher socioeconomic status (SES), and that breastfeeding and higher SES are so closely intertwined that the conclusions we draw about the benefits of breastfeeding may be the same benefits children receive from being a part of a high SES family (Colen and Ramey 2014). In other words, the advantages from breastfeeding may not come from the nutrition in breast milk itself, but rather the greater financial and social resources that breastfeeding women are likely to have relative to those who do not breastfeed. Women most likely to breastfeed are white, older, married, and educated; they are more likely to have higher household incomes, live in safer environments, and have easier access to healthcare; and they are less likely to smoke during pregnancy or have a low birth-weight baby compared to women who do not breastfeed (Gibson-Davis and Brooks-Gunn 2007; Guzzo and Lee 2008; Singh, Kogan and Dee 2007; van Rossem et al. 2009). Thus material realities and other behaviors aside from

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3 For related discussions that question whether the benefits of breastfeeding are due to the contents of breast milk or the family’s SES, and that posit that these effects are weaker than health experts claim, see Rippeyoung (2013) and Wolf (2010).
breastfeeding, not breastfeeding alone, may account for the health benefits attributed to breastfeeding.

In the remainder of the chapter I discuss my findings. In the first section, I analyze the reasons participants gave for choosing to breastfeed and connect these reasons to the ideology of intensive mothering and notions of being a good mother. Next, focusing on women who faced barriers to breastfeeding, I analyze their narratives in which they claim their identities as good mothers when exclusive breastfeeding was not attainable for them: by pushing through pain, determining and doing the best for the baby, and working hard to breastfeed. This chapter aims to build on previous research regarding new parents’ expectations and experiences with breastfeeding, particularly the moral dimensions of the dominant breastfeeding discourse and the ways women are held accountable when they use alternative feeding strategies. I add my research with couples in the U.S. to previous qualitative research conducted in countries such as Australia (Lupton 2000), the U.K. (Faircloth 2013; Lee 2007; Murphy 1999, 2000), Canada (Andrews and Knaak 2013; Fox 2009; Stearns 1999), and Norway (Andrews and Knaak 2013), as well as U.S. studies involving women (Avishai 2004, 2007; Bobel 2002) and couples (Deutsch 1999; Walzer 1998). Two decades have passed since Hays’s (1996) work detailing the contradictions women face between home and work, as well as the imperative to intensively mother, and yet—along with other changes in the gender system—the changes to more equitable parenting arrangements have likewise “stalled” (England 2010). The imperative to breastfeed has seemingly become stronger with idealizations of “natural” parenting (Bobel 2002; Wall 1999, 2001), risk discourse regarding formula-feeding (Afflerback et al. 2013;
Knaak 2010; Lee 2007; Murphy 2000; Stearns 2013; Wolf 2010), and public health campaigns and medical experts who promote breastfeeding (Bartick and Reinhold 2010; CDC 2016; Eidelman and Schanler 2012; WHO 2017). In the conclusion of this chapter, I draw out the implications of my findings.

WHY BREASTFEED?

In my antenatal interviews with expectant parents who were planning to breastfeed, I asked them questions about what breastfeeding meant, why they were choosing to breastfeed, and where their ideas about breastfeeding came from. A pattern quickly emerged in their answers: breastfeeding promotes mother-child bonding, it is healthy, free, and natural. Overall, participants believed breastfeeding (or breast milk) was the best thing a mother could provide for her child, with 10 out of 24 endorsing the popular adage “breast is best” in their first interviews. As Allie stated in her first interview:

[Breastfeeding means] doing the right thing for your kid. It’s just the most positive thing that you can do for their health, and for their mental well-being. It’s the right first step. And that’s really important for me because I want to be a good mom, and being a good mom is doing the right thing for your kid, and [breastfeeding] is the first right thing that you do.

Allie’s reasoning echoed the expert-endorsed imperative to breastfeed for the health of the child and also reflected the notion that breastfeeding is an essential practice of good

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4 To note, one of these participants, Rachel, articulated a caveat and said, “if [breastfeeding] works out, that’s the best course of action for feeding an infant.”
mothering (Faircloth 2010; Lupton 2000). Although more women than men described breastfeeding as best for the baby \((n = 7)\), four men also articulated this belief.\(^5\) As others have found (Rempel and Rempel 2011), men also support the breast is best ideology. Dave said at his first interview that he and his wife decided she would breastfeed because they wanted to be “as natural as possible and that’s the way humans began, and we want to continue with whatever is best for the baby…We just agreed that we want to breastfeed and all the benefits [of breastfeeding] far outweigh formula.” Along with the overall belief in this ideology, participants’ reasons for breastfeeding were to promote mother-child bonding, provide the best nutrition for their child, be cost-effective, and feed naturally. I briefly explain these ideas below because they show what is at stake in breastfeeding.

**Breastfeeding Promotes Mother-Child Bonding**

Most participants—men and women—believed that breastfeeding was important for fostering a mother-child bond, consistent with findings from other studies (Andrews and Knaak 2013; Lupton 2000). Chapter four of the dissertation provides an in-depth analysis of how participants framed bonding with their baby, thus my present discussion of this idea is brief. For example, Brad said that he thought breastfeeding is “good for the mother-child bond,” and Chris explained hearing from medical professionals that breastfeeding is encouraged because “it’s good for the attachment and the bonding.” Nick, although unable to point to where his thoughts on breastfeeding came from, said he thought that breastfeeding

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\(^5\) While ten individuals articulated this belief in their first interviews as I stated above, one additional participant did not clearly articulate this until the third interview.
“gives the mother an opportunity to be close with the child and have that connection…I think that’s valuable too.” Rachel believed that breastfeeding would be “a really important bonding activity for your child and to get to know your child.” And Emily, while acknowledging that she thought there were other ways for parents to bond with their children said, “I certainly think that breastfeeding will be one aspect of the way that we are able to bond, but I don’t rely on that to be the only way that we will ever bond, especially at that age.” The bonding relationship many participants expected to develop with their child through breastfeeding also reflects the emotionally absorbing aspect of the ideology of intensive mothering (Hays 1966).

Breastfeeding is Healthy

All but one participant (n = 23) said a large part of their decision to breastfeed was because they believed that breastfeeding was the healthiest feeding option for their baby. Through using words such as immunities, nutrients, and antibodies to describe why breastfeeding was the healthiest option, participants’ terminology reflected the medical discourse. Some said breastfeeding would protect the baby from illness and provide vitamins that are absent from infant formula, and that babies benefit physically and mentally from breast milk. For example, Desiree said, “I think the antibodies are huge. You can’t refute that. The colostrum is really good for the baby and gives him some immunity.” Emily said she wanted to breastfeed because “It was probably just one of those things that is ingrained in you for your entire life, that breastfeeding is always healthiest for the baby as far as getting all of the antibodies and all of the nutrients that they need.” Other participants cited health
reasons more generally. As Michael said, “So, I know some places tout health benefits [of breastfeeding]. I haven’t done in-depth research on [it]…but we kind of get the feeling there may be some more health benefits for the baby.” It is not surprising that my participants overwhelmingly cited health benefits as a reason to breastfeed. Other research has found that when people endorse the expert advice that breast milk is better for babies than infant formula, they focus on the health benefits it purportedly provides (Andrews and Knaak 2013; Dykes 2005; Faircloth 2010; Lupton 2000; Murphy 1999, 2000; Rempel and Rempel 2011).

Additionally, some participants saw the mother’s breast milk as specifically designed for her baby. In this reasoning, participants said that if the mother was unable to breastfeed, she would try pumping in order to provide the specific breast milk needed to promote the baby’s health and well-being. For example, Ashley said the most important thing to her about breastfeeding was “the nutrition and the immunity, kind of the best for the baby. That is more my driver, ‘cause I think that if [breastfeeding] doesn’t work, I’ll want to try to pump and bottle feed as opposed to—before going to formula.” Thus the strong belief in the health benefits of breast milk reinforced the medical expert advice regarding breastfeeding, and the importance of providing the healthiest option for the baby (Murphy 2000). This also implies that mothers should promote their baby’s health by providing breast milk, whatever their own feelings about breastfeeding might be (Hays 1996; Murphy, Parker, and Phipps 1998).

*Breastfeeding is Free*

In line with breastfeeding proponents and pro-breastfeeding websites, such as KellyMom.com, that argue that breastfeeding is cost-free (Barber-Madden, Petschek, and
Pakter 1987), eight of my participants articulated their belief that breastfeeding was cheaper than formula, cost-effective, or economical. For example, Holly said she thought breastfeeding was “better for the baby and it’s also a cheaper option” compared with formula. Josh said, “From a budget standpoint [breastfeeding] seems to save money.”

Michelle said that in addition to breastfeeding being healthy, she and her husband were “pretty thrifty,” so while finances were not her “primary consideration,” it was still “something to keep in mind, like if you can not buy a ton of formula and have to mess with that, that’s great.”

All of the participants’ discussions of the cost-effectiveness of breastfeeding assumed that breastfeeding would happen seamlessly, and compared the low cost of breastfeeding only to the cost of formula. No one considered losses to women’s income as a potential cost of breastfeeding (Rippeyoung and Noonan 2012). In the first interviews, participants also did not contemplate the costs associated with breastfeeding accessories, such as nursing pillows, nursing bras, breastfeeding clothes, and more (Avishai 2007). These costs could be substantial. In the third interview with Desiree and Chris, I asked about the costs associated with breastfeeding. Because of their high income, they were relatively unlimited in the types of products and services they could purchase. Desiree had tried to breastfeed for two weeks, then switched to exclusive pumping, supplementing with formula and breast milk given to her by two friends. Desiree estimated spending around $1,000 between renting a hospital-grade pump, purchasing a second pump (in addition to the pump she received for free
through the Affordable Care Act), three sets of Freemie cups,\(^6\) lactation cookies,\(^7\) and bottles. Using a pump is certainly different than breastfeeding, because it requires a machine and bottles, yet, as others have noted, breastfeeding is not as free as people assume it is (Avishai 2004, 2007).

**Breastfeeding is Natural**

The fourth reason participants gave for wanting to breastfeed was that it is “natural” (Faircloth 2010; Lupton 2000; Rempel and Rempel 2011; Schmied and Lupton 2001). Just over half of my participants (\(n = 13\)) talked about breastfeeding as natural, either by saying they were choosing to breastfeed because they believed it was natural, or they used the word natural to describe breastfeeding. When I probed for further meanings of what participants meant by natural, I discovered there was not a lot of clarity or consensus around this idea of breastfeeding as natural. Charlotte Faircloth (2013), in a study of attachment parenting and intensive mothering, documents how attachment parents use the term “natural” to account for their parenting decisions. Faircloth argues that the concept of natural is *elastic*, meaning that it could be stretched to accommodate a number of different ideas. I, too, find that the ways people described natural and the meanings they ascribed to natural highlight the term’s elasticity. “Natural” is at once biological, social, historical, instinctual, animalistic, normal, and even a term used for marketing goods.

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\(^6\) Freemie cups are a hands-free pumping attachment, “concealable collection cups,” that are designed to fit under a woman’s shirt and make pumping less conspicuous.

\(^7\) Lactation cookies are cookies made with ingredients that are supposed to boost women’s milk supply, such as brewer’s yeast, oats, and flaxseed.
Parents felt strongly about breastfeeding being natural, yet due to the elasticity of the term, there was a lack of consensus about what it meant. Participants described breastfeeding as natural in a variety of ways. Desiree said, “There’s this idea that [breastfeeding is] this natural thing and you can just do it. And it’s just anywhere, anytime.” Michelle described breast milk as a “natural product” and Graham said he thought breastfeeding was “a natural thing.” Some participants said breastfeeding seemed natural because when they were growing up, they saw others breastfeeding. Andrea said, “Everybody I knew that had babies breastfed, so I’ve always seen it as the normal and natural thing to do.” Pat described breastfeeding as “kind of a natural way [to feed].”

Current breastfeeding and parenting discourses link women, motherhood, and breastfeeding with being natural (Blum 1999). The implication of a breastfeeding discourse that frames breastfeeding as natural is that it implies that all women have the inherent capacity to breastfeed successfully, and thus breastfeeding and mothering require little support. When breastfeeding is presented as natural, convenient, simple, and enjoyable, it creates a picture of a relatively easy process that any mother should be able to succeed at and find rewarding (Braimoh and Davies 2014; Wall 2001), yet this discourse does not often match women’s experiences (Schmied and Lupton 2001). Many women do not find breastfeeding to be easy or enjoyable, and some women feel like failures if they are unable to breastfeed (Avishai 2007; Blum 1999; Braimoh and Davies 2014; Knaak 2006; Lupton 2000; Simonardottir 2016; Taylor and Wallace 2012).

Upon probing for deeper meanings participants gave to natural, some participants struggled to further define what breastfeeding as natural meant. Jill, for example,
backtracked somewhat from her description of breastfeeding as natural. She said, “I know lots of people who can’t breastfeed, and so it’s not natural for everyone to be able to breastfeed….The term ‘natural’ just doesn’t mean anything to me anymore.” Other participants used natural to describe breastfeeding in comparison to other feeding methods that they described as unnatural or artificial: infant formula and pumping. For example, Holly said that formula manufacturers are “just trying to mimic what actual breast milk is, so why not just actually use the real thing? Because, I mean, science is really good, but they can’t reproduce the same thing that the human body can make.” Additionally, when participants contrasted natural breastfeeding with pumping, they relied on the notion that pumping was done by a machine rather than the baby, or objectified the mother by making her into a machine. About this, Allie said, “[Pumping is] unnatural, and it’s just like, god, all you can do is think how much it sucks, figuratively and literally.” Having to force milk production through use of a pump made women feel like milk-production machines rather than nurturing mothers. Participants also described how breastfeeding was natural because it was connected to women’s biological ability to create and sustain life through gestation, milk production, and breastfeeding. A common theme in this narrative was the perception that women are mammals with bodies that are designed to produce life and produce sustenance for that life.

Overall, these four reasons that participants gave as reasons to breastfeed—that it promotes mother-baby bonding, it is healthy, free, and natural—reinforce the dominant breastfeeding discourse that breastfeeding is the best way to feed a baby. It is an expert-endorsed message that is heard and internalized by women and men alike. It has also
become a moral imperative for mothers and an essential practice of good mothering. Thus, women who do not or cannot breastfeed in a way that follows the dominant breastfeeding discourse risk being labeled as bad mothers. In the next section, I focus on the women who faced barriers to breastfeeding, and analyze their narratives as they sought to reconcile the challenges they faced with the good mother identity.

CLAIMING THE GOOD MOTHER IDENTITY

All the women I interviewed initially planned to exclusively breastfeed for at least six months, yet seven out of the 12 women faced barriers to breastfeeding that caused them to alter their feeding strategies, sometimes permanently (see Table 4). The different circumstances they encountered after the birth led them to use a variety of infant feeding strategies, typically including some mix of breastfeeding, pumping, formula, and other human milk, usually under expert-endorsed advice from pediatricians or lactation consultants. While their challenges prevented them from exclusively breastfeeding, they nevertheless constructed accounts that allowed them to claim the good mother identity.

Drawing on Hochschild (1994), I conceptualize women’s barriers to breastfeeding as representing “magnified moments” in their breastfeeding experiences. Hochschild defines these moments as:

Episodes of heightened importance…moments of intense glee…or moments in which things go intensely but meaningfully wrong….One thing a magnified moment magnifies is the feeling a person holds up as ideal. It shows what a person, until the experience began, wanted to feel. Thus, there is an ideal expressed in the moment
and there is culture within the ideal. Magnified moments reflect a feeling ideal both when a person joyously lives up to it or, in some spectacular way, does not…. Magnified moments show the experience we wish (4, emphases in original).

In the women’s stories I analyze here, magnified moments are those that go wrong or unexpectedly, and their narratives of coping with these moments demonstrate the ideals they wanted to live up to (see Table 4). The “culture within the ideal” is the dominant breastfeeding discourse and the ideology of intensive mothering (Hays 1996). All of the women who faced barriers to breastfeeding claimed their identities as good mothers through intensive mothering practices when exclusive breastfeeding was unattainable.
Below, I analyze the narratives women used to explain their breastfeeding difficulties and to claim their identities as good mothers: pushing through pain, determining and doing the best for the baby, and working hard to breastfeed. Rather than challenge the dominant discourse and risk further shame and judgment for their infant feeding strategies, these mothers accounted for their feeding strategies through other ways that aligned themselves...
with intensive mothering (Hays 1996), demonstrating ways they conformed to—rather than how they were deviating from—the dominant breastfeeding discourse.

**Pushing Through Pain**

Because the dominant breastfeeding discourse situates breastfeeding as natural and therefore easy (Braimoh and Davies 2014; Wall 2001), women who faced barriers to breastfeeding in terms of pain, difficulties, or a sense that breastfeeding felt unnatural rather than natural, reported feeling like they were failing at something that was supposed to be inherent to them as women (Avishai 2007; Blum 1999; Braimoh and Davies 2014; Knaak 2006; Simonardottir 2016; Taylor and Wallace 2012). While many of the mothers in my study experienced temporary pain due to breastfeeding, two mothers—Allie and Natalie—described severe and lasting pain that breastfeeding caused them, yet both of these mothers refused to stop breastfeeding. These women said their painful experiences with breastfeeding made it feel unnatural (because breastfeeding should not hurt), yet it was imperative to them to push through the pain because of their belief in the superiority of breastfeeding over formula.\(^8\) Despite feeling like failures, the ways they described pushing through the pain revealed that their efforts and refusal to give up in the face of pain made them feel like they were good mothers through their personal sacrifices.

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\(^8\) To note, both Allie and Natalie did use some formula to supplement breastfeeding, but they were both clear that the formula was an addition that made continued breastfeeding possible. As Natalie stated in her third interview, “I never really looked at [formula] as this is how I’m going to nourish her. It was more of a bookmark, just so I could heal, and keep her healthy at the same time and fed and nourished. But I never viewed [formula] as, this is what we’re going to move into doing.” Thus Natalie continued to tout the primacy of breastfeeding, despite the introduction and continued consistent use (one bottle per day) of infant formula.
For four months, pain was a large part of Natalie’s breastfeeding experience, and a significant part of her story. In her second interview, which lasted about an hour and a half, she brought up the issue of breastfeeding pain 11 separate times. Natalie’s pain was a magnified moment in her breastfeeding experience, beginning in the hospital where she described her initial breastfeeding experience as “excruciating” and “terrible.” Natalie had hoped that breastfeeding would help her feel connected to her baby, Emma, but due to the pain that breastfeeding caused her, she sometimes dreaded feedings. Natalie believed that if she was no longer in pain, then breastfeeding would be easier, better, and natural.

On the day Emma was born, the hospital pediatrician diagnosed her with a tongue-tie. While Natalie and Dave were able to have Emma’s tongue-tie clipped the next day, Natalie said her nipples were already damaged from Emma’s earliest attempts at nursing, and because Natalie did not want to stop breastfeeding, her nipples were unable to recover. She expressed how she felt about her experience with breastfeeding in the hospital:

To have [breastfeeding] feel the way that it was feeling, and have the hand pump and have the nipple shield it was sad, I was sad. I was sad for [Emma], and I was sad for me, and sad for us as a mom-baby combo that we just had been dealt this hand of cards. I wanted to give her the best chance [to breastfeed], but I knew she was struggling and I wanted to make sure she was eating. I said, “Oh my gosh, she’s

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9 Tongue-tie, medically referred to as ankyloglossia, is a condition present at birth where there is a thick or tight tissue band that connects the bottom of a baby’s tongue tip to the floor of the mouth. This tissue restricts the tongue’s movement, which can affect the baby’s ability to latch and breastfeed (Mayo Clinic 2015). Breastfeeding advocates promote having the tissue clipped, as Emma’s was, to allow the tongue to move and latch to the breast.
hungry,” and I felt like she was not able to get anything, and I didn’t want to give her formula.

Despite Natalie’s pain, because of her belief that breastfeeding was superior to formula and her desire to avoid using formula, she kept breastfeeding through the pain.

Natalie’s account of her pain is also one of self-sacrifice. Natalie recounted a story from one night when Emma was about two weeks old, and Natalie thought she heard Emma choking. Natalie said she grabbed Emma and patted her back until she coughed and cried, at which point Natalie was reassured that Emma was okay. Natalie said at that moment she realized “I would do anything for [Emma], anything, it doesn’t matter. Which is why there is no formula [in the house]. Nipple pain, no nipple pain, I would do anything for her, anything.” Natalie’s story of breastfeeding through pain is one of self-sacrifice, reflecting the ideology of intensive mothering (Hays 1996). While Natalie did not enjoy breastfeeding, which put her at risk of being labeled deviant for not being totally emotionally absorbed in the breastfeeding experience, through her narrative she claimed the good mother identity, describing her sacrifice of pushing through the pain.

Although Natalie first pumped to alleviate her engorgement, she found that pumping gave her breasts a break since pumping did not cause her the pain that breastfeeding did. She exclusively pumped for three days but then said that it was too much work, being tied to the pump while also caring for Emma, particularly when Dave was at work, so she continued to breastfeed despite the pain. While she described the frustration of “constantly cleaning” the pump parts as well as Emma’s need for constant care as reasons for not wanting to pump, Natalie’s reasoning may have also come from her fear of being judged by others for not
breastfeeding. In the third interview, Natalie recalled telling Dave one day how she felt about her body and her pain:

I felt (*big sigh*) like I was failing…I was failing as a mom, like why can’t I [breastfeed]? Why is it not happening? Why does this keep happening to me? Why do I keep bleeding? Why do I keep getting mastitis? Why am I still so engorged? I thought that my body was failing me, and I was failing [Emma]….I don’t think anybody likes sharing any kind of failure, and especially one that is being so pushed for. Oh, breastfeed, breastfeed, breastfeed; but you’re failing. Just knowing how long everybody else had done it, and falling short of that on the timeline, that was always in the back of my head.

The pain that Natalie experienced, particularly the reoccurring issues, made her feel like a failure as a mother because her body was not functioning correctly for her baby, indicating Natalie’s belief that breastfeeding should be inherent to her body. Yet her ideas of failing were also connected to her fear of judgment for not breastfeeding as long as others had. While desiring to provide breast milk for her daughter, Natalie’s narrative revealed that she was also concerned about meeting expert standards and keeping up with her friends. By pushing through the pain, Natalie’s breastfeeding was labor-intensive and emotionally absorbing (Hays 1996) in ways that “natural” breastfeeding was not, thus allowing her to claim the good mother identity.

Natalie’s pain did not last forever, though, and around the time Emma was about four months old, Natalie said that something changed. Natalie was not sure if the change was because Emma was less gassy, or if her physical development caused her to be better at
breastfeeding. With the change, Natalie described breastfeeding as “great, I have no more pain…it’s been easy.” Whereas before, breastfeeding had been a “burden,” Natalie said it became “enjoyable.” She said, “Now it just flows, it just seems natural, it just kind of happens, so it’s been easy.” Once the pain was over, her description of pain-free breastfeeding as “natural” and “easy” built from and reinforced the dominant breastfeeding discourse.

Determining and Doing the Best for Baby

Although the dominant breastfeeding discourse frames breastfeeding as the best for babies, mothers who were unable to breastfeed exclusively talked about other ways they gave their baby the best. Three of the seven women who faced barriers to breastfeeding emphasized determining and doing the best for their child in order to claim the good mother identity because they were unable to exclusively breastfeed. In their narratives, mothers also talked about their feeding strategies—although not exclusive breastfeeding—as the thing that was in fact best for their particular baby.

By relying on experts, sorting information, and thinking through the different feeding options, women’s practices reflected “scientific motherhood” (Apple 2006) in order to determine the best for their baby. The two mothers who ended up heavily relying on feeding methods other than breastfeeding talked about the lack of information available for their situation (see also Lee 2007), such as Ashley who said at the third interview:

I didn’t feel like there was a lot of information. There’s information on bottle-feeding and there’s information on breastfeeding, but the whole, trying to make it work, the
combo, I felt like that wasn’t as—I don’t know people that talk about it, and I didn’t find as much information on that, so I think it was hard in that, I’d breastfeed her and it’s like, “Okay, are you full or do I need to top you off with formula?”

According to Ashley, not only could she not find information about combining formula and breastfeeding, but parents in her social circles were not readily sharing stories about their infant feeding strategies that deviated from exclusive breastfeeding. She suggests that parents’—and likely mothers’—fears of judgment or shame for not exclusively breastfeeding may keep them quiet about this topic. Ashley said she eventually asked her friends about their feeding experiences, and learned that while several of them had bottle-fed, “it just doesn’t seem like it’s something that people talk about a whole lot.” Ashley also indicated her desire to follow expert advice regarding how much to feed her daughter, not knowing how much of “the combo” of milk and formula she should receive.

Even though not breastfeeding is deemed risky behavior, in terms of medical experts’ views on the healthiest ways to feed babies, mothers who were unable to exclusively breastfeed described the lengths they went to in order to find the best way to feed their baby that reduced risk to the baby’s health. By stressing the ways their feeding strategy reduced risk to the baby and was child-centered (the best for my child), women performed “good” mothering. Additionally, talking about the ways they worked hard to breastfeed was a way to distance themselves from being labeled selfish, because their feeding strategy was child-centered.

Desiree was unable to get her son, James, to latch to her breast. Ultimately, she decided to exclusively pump rather than give him formula because of her belief that breast
milk was superior to formula. But in describing her desire to do the best for her son, she also pointed to the social pressure to breastfeed based on public health recommendations and attachment discourse:

I think being the kind of person that I am, I was like, I’m going to do what’s absolutely best for my child. And I was really worried about the attachment issues and stuff, like bonding with mother and baby and stuff like that, ‘cause you read all this on the La Leche site or on KellyMom\(^{10}\) and you feel like a jerk if you don’t follow exactly what is recommended, you know? There’s whole threads on getting a baby back to the breast….And even when I was at this mom [support] group, you know, the boobs were all out, 10 women, boobs out everywhere, and I’m sitting there with my bottle (laughs). And you just feel less than, in a way.

Desiree’s description of feeling inferior to the other women who were breastfeeding their babies while she bottle-fed her son at a support group, points to her feelings of being deviant around other breastfeeding mothers. While these types of (typically pro-breastfeeding) groups are promoted as being support groups for new mothers, they may also reinforce the dominant breastfeeding discourse and reinforce the stigmatization of women who cannot or do not breastfeed (Carter 1995; Taylor and Wallace 2012).

In emphasizing their efforts to do what is best for the baby, mothers stressed the ways they followed expert advice. Ashley, for example, had what her doctor deemed a low milk supply. After one month of trying to increase her milk supply, the pediatrician told Ashley

\(^{10}\) The La Leche League website and KellyMom.com are pro-breastfeeding websites that purportedly provide mother-to-mother support and breastfeeding information, and evidence-based information about parenting and breastfeeding, respectively.
that her daughter, Olivia, was not gaining enough weight and she needed to supplement her breast milk with formula. Ashley said the pediatrician “didn’t talk about how to make breastfeeding work otherwise,” which she was critical of, yet, “I wanted what was best for [Olivia] so, you know, if it wasn’t working with me [breastfeeding] then yes, I was going to supplement and not just starve her.” Thus while Ashley did not find Olivia’s pediatrician supportive of her preference for exclusive breastfeeding, she nevertheless relied on the pediatrician’s advice to use formula. But she also framed her decision as doing the best for Olivia because she was not going to allow Olivia to “starve,” an obviously negative health outcome. Additionally, Ashley subordinated her desire to exclusively breastfeed because she “wanted what was best for Olivia,” thus rendering her decision child-centered.

Women who framed their feeding strategies as determining and doing what was best for the baby stressed the ways they followed expert advice, used the best option available for their particular child, went to great lengths to avoid exposing their child to risk, and/or subordinated their own breastfeeding desires. In this way, they claimed the good mother identity through their narratives, even when the best option—exclusive breastfeeding—was unavailable.

*Working Hard to Breastfeed*

Six of the seven mothers explicitly talked about how hard they worked to overcome the breastfeeding barriers they encountered. Because intensive mothering is labor-intensive, working hard to breastfeed is in line with intensive mothering (Hays 1996), thus allowing these women to claim the good mother identity. For example, in the third interview, Allie
described breastfeeding as “a work in progress” and “hard” and discussed how her efforts to
breastfeed for as long as she had made it harder for her to “give it up”:

It’s bittersweet for sure because I worked so hard to [breastfeed]. Because for me it
has not been a natural, easy thing. It’s been a work in progress. It’s been hard. It’s
been really, really hard and so it’s kind of, I don’t want to give it up just for the sheer
fact that I’ve had to work so hard to do it and make it this long.

The mothers who worked hard felt proud of their accomplishments in two main ways: taking
the harder road and sticking with it.

While most of the participants acknowledged that breastfeeding was often hard, those
who faced barriers to exclusive breastfeeding spoke with pride about the ways they
accomplished giving their infants breast milk. Ashley and Pat talked about taking the
“harder road” as Pat called it, when it came to their infant feeding choices. Ashley described
the pride she felt in their decision to continue breastfeeding, even though their daughter
Olivia was receiving most of her nourishment through formula:

[Breastfeeding was] an ideal that I had hoped for, something that you think about and
you think it’s going to work one way….It was a lot harder than I thought it was going
to be that it didn’t work out. It just felt like it was something as a mom that I should
be able to do and wanted to do, so whether that’s rational or not, it just is something
that I hoped to do….And I’m still [breastfeeding] and I’m kind of proud of it because
once we started doing the combo thing [with breastfeeding and formula] it was like,
this would be a lot easier if we just quit breastfeeding and did bottles because we’d
know how much she was getting….I am proud that we’re still doing it and that we
kept with the breastfeeding even after because as soon as we started going to the bottles it was like, this would be a lot easier if we just went 100 percent the bottle way.

Ashley’s sense of pride came from not taking the easy way out by “just” bottle-feeding her daughter with formula. She acknowledged internalizing the dominant breastfeeding discourse that positions women’s bodies as inherently able to breastfeed when she said that “as a mom” she thought she “should be able to [breastfeed].” But by working hard to do the “combo thing,” she was able to claim an identity as a good mother.

The second way that women talked about working hard was through their endurance or sticking with breastfeeding even when it did not seem to be working. It took Michelle 11 days of pumping for her milk to come in,11 so for the first couple of weeks after her baby’s birth, she followed an intense pumping schedule and fed the baby with bottles of formula. She described being rigorous with breastfeeding and pumping, working to build up her supply, and then intensifying again before returning to work. Sometimes Michelle would wake up in the night to pump even if the baby did not wake up. She said at the third interview, “It made me feel really good that we were able to do it. It’s kind of silly that it did, but it totally did, like, we worked really hard….I’m proud of the fact that we were able to [breastfeed].”

Similarly, Holly described how happy she was that she had stuck with breastfeeding. Her son, William, went through a “nursing strike” that lasted a couple of months, so she

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11 Typically, the breasts first produce colostrum, and then after three or four days, the milk comes in.
exclusively pumped during that time and fed him breast milk from a bottle, a process she described as incredibly frustrating. At the end of Holly and Michael’s third interview she said:

It’s been nice just talking about [our experience] with some of the struggles that we’ve had, [it’s] just nice knowing, ah, we’re six months in and it’s finally easy, it’s really nice, (laughs). And it’s nice to report that. We’re troupers and we stuck with it and now I feel successful.

Although Holly used “we” throughout this excerpt, she switched to “I” when she discussed feeling like a success, emphasizing how much a mother’s identity, in particular, hinges on breastfeeding. Thus Michelle and Holly constructed narratives that involved overcoming magnified moments of breastfeeding barriers through their endurance and persistence.

I followed up with the families when their children were one year old, and I asked them again, why choose to breastfeed? Holly’s main reasons were that breastfeeding promotes mother-child bonding and is healthy; however, her narrative indicated that breastfeeding, despite the challenges she faced, also reinforced her identity as a “good mom”:

We chose to breastfeed because it provides us another way to bond and I know breast milk is the best thing for him. My reasons for breastfeeding haven’t changed since the beginning. It makes me feel good as a mom to provide my baby with milk, it’s time for bonding, and it has helped keep my baby healthy.

While it took a lot of work and endurance for Holly to feel like she had a “successful” breastfeeding experience, her narrative at the one-year follow up continued to reflect the
dominant breastfeeding discourse. Her hard work and her success thus reinforced her claim on the good mother identity.

CONCLUSION

The idea that breastfeeding is the best feeding option for infants is part of the ideology of intensive mothering. In line with the dominant view, participants endorsed breastfeeding on the grounds that it promotes mother-child bonding, it is healthy, free, and natural. Participants constructed breastfeeding as natural, in contrast to using formula or a breast pump, by framing it as fundamental to the female body. These meanings helped to reinforce the dominant view that breastfeeding should be natural and easy for women (Braimoh and Davies 2014; Wall 2001). I then analyzed narratives surrounding women’s “magnified moments” (Hochschild 1994) in their breastfeeding experiences, when breastfeeding did not go as expected. Through their accounts of pushing through pain, determining and doing the best for baby, and working hard to breastfeed, women claimed the good mother identity by fitting into—rather than challenging—the dominant breastfeeding discourse.

I opened this chapter with a quote from Allie’s second interview. At that point, Allie had wrestled with nipple pain, caused by using a nipple shield that was too small. While she said her breastfeeding experience was “wild” (meaning good) and that she “wouldn’t trade any of it for anything,” she also experienced challenges to her identity as a mother because breastfeeding did not come naturally or easily to her, nor was her body “naturally equipped,” as she put it, to breastfeed, as she thought it would be. Before her son’s birth, Allie hoped to
breastfeed for one year, but she stopped when he was 10 months old. When I followed up with her at the one-year mark, Allie emphasized the importance of doing what’s best for the baby but also said it was important to give mothers a break if they are not 100 percent successful at breastfeeding:

Did you try your best? Yes. Did you do your best without driving yourself up the wall? Ok, that’s good enough. Give yourself a damn break. That’s what I got out of it….I think it’s awesome if you want to breastfeed, I think breast is best and give it your best shot, and definitely give it a try ‘cause it’s wonderful and it’s worth it. But if you’re not perfect at it, that’s ok, and don’t plan on being perfect at it, ‘cause guess what? It’s a learned skill, for you and the baby….If it doesn’t happen for you that’s okay, that doesn’t mean you’re failing. It comes in all shapes and sizes, just like people. You just got to deal with it the best you can….And I do feel like I’m a better parent because I gave it my best. I think there’s truth to that.

Even though Allie gave mothers permission in the abstract to not be “perfect,” she still held herself to a high standard of giving her best effort and said that this enabled her to feel like a “better parent.” To be a good mother, one must, in the end, “try your best.”

Yet, the idea of what qualifies as “best” remains somewhat elusive. While some participants assert doing their best—such as Allie in the above excerpt—other participants brought up examples of people they knew who did not breastfeed, indicating that these non-breastfeeding families likely could have made breastfeeding “work” if they were more committed to it. While I focused this chapter on the seven women who faced barriers to breastfeeding, there were five other women who faced relatively few challenges. The ways
these women talked about mothers who did not breastfeed sometimes reflected the fear of judgment or shame that those who faced challenges articulated. Andrea and Josh were one such couple. At the third interview, Andrea described her breastfeeding experience as “relatively smooth sailing” and wondered what kinds of challenges other participants had faced, based on the questions I asked. Andrea exclusively breastfed her daughter for nine months before deciding to supplement with formula rather than continuing to pump at work. During the time she was exclusively breastfeeding, Andrea’s narrative continually reinforced the dominant breastfeeding discourse, particularly emphasizing that women’s bodies and babies were designed to breastfeed. At the third interview, she said:

I think the babies are born to [breastfeed], it was in their design. So, I think a lot of people say it doesn’t work, when they probably could have made it work. But again, I’m not in their situation, I don’t know what’s going on. You have to do what’s best for your family.

Her narrative revealed an inherent contradiction: women likely can and should make breastfeeding work; however, they should also do what is “best” for their family. Thus, they will likely be held accountable for their feeding decisions when they are not breastfeeding, regardless of trying their “best.” Later in the interview, in talking about people Andrea and Josh knew who were not breastfeeding, Andrea said her friends “wanted to [breastfeed], but none of them seemed committed enough to let the baby have the time that they needed to make it work.” Josh similarly articulated, “Yeah, I had a coworker who claimed that [breastfeeding] just didn’t work; they couldn’t get [the baby] to really latch.” By using the word “claimed,” Josh indicated that he did not take his coworker’s reason seriously. Thus,
despite the earlier assertion that parents should “do what’s best for [their] family,” Andrea and Josh’s narratives reflected the dominant breastfeeding discourse and revealed the lengths that parents must go through to achieve this elusive “best”: remaining committed to it and making it work. Even then, trying your best may not be enough.

Whereas breastfeeding may be framed as natural, cultural norms of breastfeeding are socially constructed, including how to breastfeed, when to breastfeed, how long to breastfeed, with whom to breastfeed, whether to rely on a breastfeeding expert, and so on. These norms matter. Women who cannot or do not breastfeed may feel guilty and think they are not doing the best for their baby. They may feel like failures, as Natalie did, if they internalize the message that natural breastfeeding is inherent to women’s bodies. They may feel judged or stigmatized, as Desiree did, if they feed their baby with a bottle while surrounded by breastfeeding mothers. And, as Andrea and Josh’s narrative demonstrated, their fears are not unfounded. Participants’ narratives repeatedly revealed ways they felt accountable for their feeding decisions, thereby claiming their identities as good mothers and fitting into the dominant “breast is best” discourse rather than risk being labeled bad mothers.

Additionally, as women face barriers to breastfeeding, they may hesitate to seek out support because, if breastfeeding is supposed to be natural and easy, support should not be necessary. For example, Rachel, who faced initial breastfeeding challenges, said calling a lactation consultant was “a symbol of failure.” Ultimately, however, she did meet with a lactation consultant and her experience was positive. Other participants also emphasized the help and support they gained from lactation consultants. Yet if there is stigma around needing help, then some will be unwilling to seek it out. Thus, one way to support women
who are trying to breastfeed would be to challenge the dominant breastfeeding discourse by asserting that breastfeeding may not be natural, easy, or inherent to women’s bodies.

Another way to support women who are trying to breastfeed would be to emphasize the importance of considering a mother’s health in addition to an infant’s health. The women in my study who experienced breastfeeding challenges expressed a tremendous amount of distress. The pressure women face to breastfeed comes from both medical experts as well as friends, family, and even strangers in face-to-face interactions or on social media. As my research reveals, these pressures can lead women to suffer through weeks and even months of pain and to sacrifice their own well-being as they seek to do the best for the baby. If breastfeeding does not allow a woman to live a healthy life, then perhaps it is not the healthiest option for her, or her family.

Finally, there are structural ways to support parents. I discuss many such supports throughout the dissertation, such as greater workplace flexibility and access to high-quality healthcare. Here I focus on providing access to breast milk apart from breastfeeding. While medical experts and public health discourses actively promote breast milk as the healthiest option for babies, if a woman cannot breastfeed her own child, breast milk may be difficult to obtain. Breast milk can be purchased from a Human Milk Bank—where donated milk is screened and pasteurized—however, doing so requires a doctor’s prescription as well as the availability of the milk.12 Only one couple in my study, Holly and Michael, purchased

12 While none of my participants could speak to this experience, aside from Holly and Michael, a friend of mine described attempting to purchase human milk, having to call the hospital each day to see if there was any milk available, and sometimes there was none, or it was kept on reserve for premature babies in the hospital. She said she spent several hundred dollars for a few days’ worth of milk, a practice that was ultimately unsustainable.
human milk immediately after their child’s birth, under the advisement of a lactation consultant. Holly said it cost $22.00 for four ounces, which is, at the very least, 18 times more expensive than formula.  Thus, pasteurized human milk is neither readily available nor inexpensive.

Another option for obtaining breast milk is informal milk sharing, although this practice is discouraged by the Food and Drug Administration (FDA) because unregulated milk can be contaminated (AAP Committee on Nutrition 2017). Recent studies demonstrate that informal milk-sharing, whereby women give or sell their milk to other women, is prevalent (O’Sullivan, Geraghty, and Rasmussen 2016; Palmquist and Doehler 2016; Perrin et al. 2014; Reyes-Foster, Carter, and Hinojosa 2017), despite the FDA’s disapproval. Yet one study found that newspaper articles represented women who participated in milk sharing practices as ill-informed about the potential risks to their babies and morally reprehensible (Carter, Reyes-Foster, and Rogers 2015). Thus women may feel stigmatized for participating in informal milk sharing and may worry that, by doing so, they are putting their babies at risk.

Ironically, while formula is often demonized, particularly by breastfeeding advocates, it is readily available and covered by WIC (the Special Supplemental Nutrition Program for Women, Infants, and Children). If screened and pasteurized breast milk was likewise readily available and covered by WIC, it would be more accessible to mothers with fewer resources,

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13 According to KellyMom.com, the cost of formula ranged from $0.08 to $0.31 per ounce in 2016.
14 Two of the families used large amounts of other human milk they obtained from friends who they said they knew and trusted. None of my participants used unpasteurized human milk from people they did not know.
as well as to those who may face difficulties breastfeeding but want to provide breast milk.\textsuperscript{15} Providing families with multiple safe and healthy ways to feed their infants without relying solely on a mother’s body to produce such nourishment may be one way to support a broad array of families and to challenge the dominant breastfeeding discourse.\textsuperscript{16}

\textsuperscript{15} This may not be the case, however, as several of my participants said that they would rather use formula than another woman’s breast milk. For example, Allie said she believed that “the point of breastfeeding is that it’s from you to your baby” and therefore would not want someone else’s breast milk.

\textsuperscript{16} Providing families with access to other women’s breast milk obviously raises the questions of who supplies the milk. While I am not suggesting that women should pump for pay, the research regarding informal milk sharing suggests that women \textit{are} producing extra milk that is often donated to other mothers. There is clearly an informal and unregulated market for this milk. Thus rather than condemning the milk sharing practice, the public health system could support families by providing greater access to pasteurizing milk.
I think now breastfeeding is more of a bonding thing, it’s just nice. I don’t think I anticipated how nice it would be to just curl up with her, and she’s happy and I’m calm and it’s quiet and nice. It’s just very pleasant, and I think before doing it I was concerned that it would be strange to have a small person attached to my body all the time. It’s not strange at all, it’s super nice, it’s just very soothing and sweet. I think that’s now the biggest reason to breastfeed, it’s nice and it’s good for her and I like it, so it has all those benefits. So all the things I thought would be—the ease, the cheapness, yada yada—I don’t know that we’re saving any money. I don’t know that it’s that much easier than having formula would be. But it’s very calming and nice and sweet, and it’s time that I spend with her that I’m not doing much else, and I’m really focused on her and she’s really focused on me. I think we have bonded a lot just because we made this effort to breastfeed. — Michelle, third interview

INTRODUCTION

Breastfeeding literature promotes bonding with baby as one of the primary benefits of breastfeeding. For example, the Office on Women’s Health, a division of the U.S. Department of Health and Human Services, states at the top of their breastfeeding fact sheet that “The experience of breastfeeding is special for so many reasons: the joyful closeness and bonding with your baby…” (Office on Women’s Health 2014, emphases added). This government department is ostensibly focused on health yet cites bonding as one of the top reasons to breastfeed. In line with this, most participants—men and women—articulated hearing about bonding through breastfeeding from friends, learning about it in a class they were taking (for birth or breastfeeding), or reading about it in their breastfeeding research. Many participants expressed that mother-child bonding was an important reason to breastfeed.
In their narratives, participants framed bonding with their baby through feeding practices as a special activity. This specialness served to exclude outsiders from the mother-child bond, yet at the same time, many of the participants actively worked to include fathers in the feeding and thereby the bonding. Participants’ desires and efforts to include fathers in the bonding experience may appear to be an act that is based on increased gender egalitarian ideals and one that encourages more egalitarian childcare practices, especially as couples’ narratives revealed attempts to share the load of caring for a new baby. On the surface, men’s involvement in feeding and bonding with their child appears to reduce women’s childcare labor. However, my analysis suggests that these practices may have added to women’s invisible labor of childcare (Daniels 1987). For example, women—not men—strategized during pregnancy about how to help men bond with the baby after the baby’s birth. The desire to include fathers in the breastfeeding bond can, therefore, further burden mothers and maintain gender inequality within families (Fox 2009; Walzer 1998) when women take on the physical and emotional role of orchestrating this outcome.

Furthermore, there were consequences for families when participants used the bond through breastfeeding as a reason to exclude others. As couples worked to include men in the feeding, some also worked to exclude outsiders because of their belief in the bond that breastfeeding created. They excluded outsiders in order to preserve and protect the bond, despite the strains it placed on their resources. This practice highlights couples’ individualistic and privatized strategies for childcare.

More broadly, excluding others is a behavior of what I term family gatekeeping. Whereas Allen and Hawkins (1999) define maternal gatekeeping as “a collection of beliefs
and behaviors that ultimately inhibits a collaborative effort between men and women in family work by limiting men’s opportunities for learning and growing through caring for home and children” (200), I broaden this concept to the nuclear family. Family gatekeeping, therefore, is a collection of beliefs and behaviors that can serve to inhibit the inclusion of people outside the nuclear family, thereby limiting the opportunities for outsiders to interact with and help the family. One behavior of family gatekeeping is practicing inverted quarantine (Szasz 2007) whereby families attempt to isolate themselves from what they believe is a toxic environment. My analysis reveals that couples protected the breastfeeding bond by practicing family gatekeeping.

In contrast to the families who practiced family gatekeeping by excluding potential helpful outsiders, other families retrospectively included outsiders in the bond. This happened after unforeseen challenges arose after the baby’s birth, and the families accepted outside help. In their narratives, they give an account of the outside help, and reframe the situation to effectively raise the status of the outsider to a (temporary) parent. To further clarify the retrospective aspect, it was not in the moment that these parents wanted the outsider to bond with their baby. Instead, parents reflected back at the help and support from the outsider, and then included them in the bond. These parents highlighted the importance of their individual choices and behaviors to do the best for the baby and themselves. Despite being different in practice, I argue that both excluding and including others highlight the individualistic and privatized nature of caregiving as they both involve couples drawing on their private resources to cope with their situations.
The ways participants practiced excluding or including others as they tried to create and protect the bond of breastfeeding provides insights into intimate family dynamics, gender inequality, and the individualistic and privatized nature of breastfeeding specifically and childcare in general. Maintaining the bond with baby involved a great deal of emotion work as parents, and particularly mothers, faced a collision between the reality of being a new parent and the idealizations that they had been investing in as they awaited the birth of their baby (Hochschild 1979). New parents often described wanting to share the load of caring for a new baby, while at the same time practice exclusive breastfeeding. This led women to take on additional mental labor (Walzer 1998) as they strategized about how to include men in the feeding, and thereby the bonding. This “third shift” of family emotion work (Hochschild 1997) remained invisible to mothers and fathers alike, thereby reproducing gender inequality at home (Fox 2009; Walzer 1998) and reinforcing the ideology of intensive mothering (Hays 1996). The emotion work that women did around bonding took a toll on their relationships with others as well as on their identities as mothers.

In this chapter, I first demonstrate what the bond meant to participants and how they tried to achieve it. Second, I explain how women strived to include men in the bond with the baby, which involved mental labor on the part of the women. Third, I discuss the ways the processes of excluding and including outsiders reinforced privatized practices of childcare. Overall, my findings demonstrate how inequality is reproduced within and between families.

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17 When participants talked about breastfeeding, they often meant exclusive breastfeeding, meaning the baby should only be breastfed by the mother through the breast, not through a bottle, although many of them discussed plans to introduce a bottle at a later point. One reason participants gave for wanting to exclusively breastfeed was to avoid nipple confusion, which is the concern that once a baby drinks from a bottle, s/he will no longer return to the breast.
as individual solutions are applied to social problems, reinforcing the devaluation of childcare specifically, and care work more generally.

CREATING THE BREASTFEEDING BOND

Participants framed bonding with their child through feeding practices as a special activity. What does “bonding” mean? In this chapter, when I discuss how parents conceptualized being bonded to their child, I demonstrate how they defined this bond as more than feeling a connection with the child. Bonding was an ideal that parents wanted to achieve, even though some believed it would spontaneously occur through breastfeeding. Participants often described how they bonded (or wanted to bond) with their baby through breastfeeding with words such as magic, special, sacrifice, amazing, and unreal. Some participants described being in awe of breastfeeding because they watched their baby grow, develop, and respond to breastfeeding. Others said that the feeling they got when feeding their child with a bottle was indescribable. Shawn, for example, said giving his son a bottle is “just a special moment and I can’t, um, I can’t really describe it.” Across time points, participants expected to have deep, meaningful, and intimate connections with their children, and many assumed this would begin through infant feeding, especially breastfeeding.

Prior to the baby’s birth, participants routinely emphasized bonding with their baby as one of the primary reasons to breastfeed. Some attributed this assumption to a continuation of the mother’s connection to the child growing inside her body. Robert said breastfeeding would be about “creating that closeness” for his partner, Allie, “after having had a child in her body for nine months, to maintain closeness and increase that nurturing and emotional
connection…it’s a natural process.” Rachel emphasized the connection that breastfeeding mothers supposedly develop with their child, saying “I think a lot of mothers who breastfeed are more into the rhythms of their child.” Holly also indicated that she anticipated breastfeeding would allow her to “bond with the baby” and that “it would be special.” As I discuss in detail in the next section, women also often expressed wanting to include their husbands, and worrying that their husbands would be excluded from bonding with their child because the men would not be breastfeeding.

After the baby’s birth, some mothers and fathers found that feeding provided a way to bond with their baby, whereas others did not. Yet even when they did not feel bonded with their child, participants continued to wish or strive for the bond through breastfeeding. Some indicated that perhaps they would achieve the bond through breastfeeding with a subsequent child, such as Desiree who said, “maybe I’d get that magic” if she had “a baby that latches perfectly, [then I’d] get to have more of a real breastfeeding experience.” Desiree did not consider her current breastfeeding experience—exclusive pumping—to be “real breastfeeding.” But Desiree also attributed agency to the child, pointing to the necessity of a perfect latch in order for breastfeeding to work, which underscores how infants may not be passive participants in the breastfeeding dyad (Wayland 2004). Some fathers found that bottle-feeding was a special way to be involved in childcare in the early days, whereas other fathers said that the routine, mundane aspect of feeding did not lead to a bond but instead felt like a “chore.” Whereas none of the women called feeding a chore, women who experienced painful breastfeeding said it was more of a “burden” than the enjoyable experience they were
told it would be. As new mothers and fathers experienced breastfeeding, I found three ways they framed bonding through breastfeeding.

First, participants described their amazement with the ways women’s bodies responded to breastfeeding, and they believed this physical response provided a connection to their child. Allie said she was surprised and amazed by what breastfeeding “does to your body” and that “the physiological connection that your body has with someone that is no longer connected to [your womb] is amazing.” Interestingly, Allie said it was the baby who was directing her body’s responses, not the stimuli. She went on to describe how her baby, Noah, did this:

Noah latches on and my uterus cramps down, you know, like, that’s amazing, or you know, Noah latches on and I get a headache, you know. That’s because there’s certain hormones happening or he cries and my milk lets down, like, how does that happen? You know, like, that’s amazing.

Similarly, Catherine described her body’s response to breastfeeding: “It’s just coming from your body, it’s like just the response your brain gives and everything. I just think it’s incredible.” Josh indicated with amazement with how his wife’s body responded to how often the baby nursed: “The mother’s supply and demand comes from the baby, the baby’s nursing more often, or getting more at a time, like the body literally produces more milk…. The connection, the response is so high.” Although the participants described how women’s bodies responded to their babies, what their bodies are actually responding to is the
stimulation of the suckling on the breast\textsuperscript{18} (Ramsay et al. 2004). Participants’ amazement at this physical response of the mother to the child helped to elevate breastfeeding as a very special activity because they conceptualized it as not merely feeding their babies, but in terms of their bodies responding to their babies through breastfeeding.

Women also juxtaposed the bond created through breastfeeding with their disdain for the breast pump, even though some men said feeding the baby with pumped milk helped them bond with the baby. Pumping mimics the baby’s suckling, stimulating the milk-ejection reflex, and women’s bodies respond similarly to pumping as to breastfeeding, yet participants’ narratives lacked a sense of amazement about the physical response of women’s bodies to the pump. Rachel and Nick’s exchange at their third interview provides insight into this point. While discussing breastfeeding, Rachel brought up pumping and said, “I’m so tired of pumping. I’m sick of it.” The following exchange ensued:

Nick: I’m about ready to throw that thing in the yard.

Rachel: Yeah, I wanna throw it and drive over it with the car….Pumping is so tiring. My best friend told me that when she found out she was pregnant and she opened up her linen closet and saw the pump up there she just started crying. She was just so miserable.

Nick: Well the pump has been good because of what I’m doing right now, you know. It allowed me…about three weeks in…I started feeding [the baby] with Rachel’s pumped milk. Rachel’d pump and I’d feed him, and he and I started getting a lot closer at that point. Whereas before then I was just standing around like, “What can I get you, can I get you a glass of water? What do you want? What can I do?”

\textsuperscript{18} This is called the milk-ejection reflex, where “suckling stimulates the posterior pituitary gland to release oxytocin, which causes the contraction of the myoepithelial cells surrounding the alveoli, forcing milk from the alveoli into the milk ducts” (Ramsay et al. 2004: 361). In humans, milk removal depends on effective stimulation of the milk-ejection reflex (Ramsay et al. 2004).
Here, Nick described feeling like a peripheral parent, standing on the sidelines while Rachel did all the work. Whereas Rachel expressed many times in her interviews how supported she felt by Nick, and how much he took care of her needs, Nick’s description in the above exchange underscores that supporting Rachel did not bring him closer to the baby, and it was not until he also participated in the feedings that he felt bonded with the baby. Later in the interview Rachel continued to describe pumping:

[It’s] a necessary evil…[I] just get so sick of it. It’s like Chinese water torture or something, it’s just constant, (makes noise of pumping machine) “kathunk-kathunk.” [I’m] just sitting in there, and it’s not like feeding him…It’s just a pain…It’s uncomfortable, it doesn’t feel that good to pump, and it’s just, yeah and it’s boring and it’s necessary.

For Rachel, pumping was “necessary” when she woke up feeling engorged because the baby had not breastfed in the night. It was also “necessary” so that she could be away from the baby while she worked. Another way women described pumping was feeling like a cow, as Holly said in her third interview: “I feel like an old milk cow sometimes, especially when I was pumping constantly and [the baby] wasn’t nursing at all. That’s all I felt like: a cow. It’s like, alright, let me hook up again.” The women’s descriptions of pumping suggest they were not connected or bonded with the pump in the same way they were with their babies.

The second way participants framed bonding through breastfeeding was by extending it far beyond a physical act: participants indicated that breastfeeding also provided an emotional connection with their child. For example, Allie wondered whether non-breastfeeding mothers could bond with their child in the same way and pondered whether the
depth of their love for their child would be as great without breastfeeding. Although she attributed her physical and emotional bond to her child to the hormones in her body, she also believed that breastfeeding allowed her to love her child deeper because they were “in the trenches together” as they worked to establish breastfeeding. Reflecting on breastfeeding at her third interview, Allie said:

I knew [breastfeeding] was, like, an innate physical thing and chemical thing that happened…but I did not realize the actual emotional bond that came from it, you know. I mean, I knew we were going to be emotionally bonded, but I didn’t realize what it was going to do to us because we are like, it’s like, he needs me, I need him, it’s amazing. Like I never even thought about how deep it could be…I mean I can understand how you still love your child if you give them a bottle from day one. I get that. But I don’t—I know it would not be to the depth that it is without breastfeeding. For Allie, breastfeeding provided a powerful connection with her son that she believed would not have come if she had fed him from a bottle, and part of this connection was the “emotional bond” that drew her and her son together.

The third way participants described the breastfeeding bond involved how they talked about the baby’s response to breastfeeding. Participants suggested that infants can be willful and agentic, able to do breastfeeding in both “right” and “wrong” ways. For example, Molly’s son was born five weeks early and was fed through a feeding tube and then with bottles for two weeks, so she articulated amazement that he seemed to know what he was “looking for” when she fed him from the breast. “The first time or two he started latching [it] was actually a really cool feeling to see him do that and have it, you know, come so
naturally to him, that that’s what he was looking for.” Molly did not think breastfeeding would be a “big bonding thing,” but the bond developed when she saw how “natural” breastfeeding was for her son. Similarly, Allie described the “symbiotic relationship” she shared with her son through breastfeeding. Whereas prior to his birth she had planned to breastfeed for six months, she said breastfeeding provided such a strong bond that she wanted to breastfeed longer, “if anything, just to keep our connection going.” Allie said she began to “pick up on” Noah’s cues and “read [his] emotions” because she recognized that “sometimes he does just want to be soothed and just, you know, suckle and just be close. You can tell the difference when he’s hungry and when he just wants to be held to the breast.” Allie was amazed because she said, “I never thought I would be able to read emotions like that.” Yet the things Allie described were not emotions per se, but rather behaviors that her baby displayed. Emily said the most enjoyable thing to her about breastfeeding was “how attached [my daughter] gets to me when she’s breastfeeding, especially with her hand movements…the way that she touches me or caresses me when we’re actually breastfeeding, that is more of a bonding thing for me.” Although Emily recognized that the baby was “not necessarily doing it on purpose” because she was so young, similar to Molly and Allie, the baby’s agency of wanting to breastfeed and the baby’s physical attachment to the mother through breastfeeding were central to the ways participants constructed the breastfeeding bond.

In contrast to the participants who spoke of their infants’ agentic ability to breastfeed correctly, Desiree revealed anger at her son’s inability to latch properly, thereby assigning
him agency as well. Desiree explained that her painful breastfeeding experience in the hospital prevented bonding with her newborn:

[The baby] was ripping up my nipples every time he ate and he was really frustrated and I was really frustrated. I felt like it was getting in the way of us trying to bond. I was kind of angry at him for like, why can’t you do this right? Desiree pointed to feeling angry with the baby for not “do[ing] this right,” saying she would have felt a more immediate connection with him had breastfeeding gone smoothly. Just as babies, as agentic beings, could breastfeed correctly and thereby accomplish bonding, babies were also agentic beings who could breastfed incorrectly and subvert bonding.

Although newborn babies are independent in the sense that they breathe and have a heartbeat, they are also completely physically, emotionally, and socially dependent on others for their survival (Redshaw 2014). Yet over the past several decades, a variety of discourses and technology have effectively assigned infants and even fetuses in utero subjectivity. Bordo (1993) describes the increasing subjectification of the fetus, specifically in light of abortion debates, and brings attention to the fetal-rights position that constructs fetuses as “super-subjects” (88), in contrast with the pregnant women who carry and are held responsible for the fetus, but whose subjectivities are denied. My participants often attributed agency to their infants in regard to feeding, thus making breastfeeding a bilateral decision, instead of caregivers making the feeding decisions and infants passively complying (Wayland 2004). In a society that holds mothers ultimately responsible for their children’s well-being (Hays 1996), assigning agency to infants may be one strategy women use to repudiate mother-blame (Blum 2007), while at the same time inserting their children into a
social narrative which recognizes infants as having needs and desires (Redshaw 2014) and beginning an early pattern of concerted cultivation (Lareau 2003) by allowing infants to “lead the way” in feeding.

In contrast to the women who described breastfeeding as being “in the trenches” with their baby or “troupers [who] stuck with it,” men described how bottle-feeding made them feel “important” and “involved” with their children. Feeding their children was something they could do to be active, involved fathers, rather than peripheral characters, as Nick articulated earlier. Molly’s partner, Jason, was supportive and encouraging of breastfeeding, but he also enjoyed being able to feed their baby, Liam, with bottles of Molly’s pumped milk. Molly pumped consistently for two months and then switched to mostly breastfeeding. In the early weeks of Liam’s life, Jason said that feeding Liam was a way to bond with his son. Jason said bottle-feeding “does help you feel a little more of a connection…definitely helps make you feel important and [is a way to] be a part of his life.” Although there are many ways for non-breastfeeding partners to be involved in parenting, Jason indicated that feeding his son made him feel equal to Molly:

It’s not just Molly feeding him and me just watching from the corner, you know, I actually get to hold him, feed him, change him, do everything. So, you feel like, you know, you’re just as important as she is even though she’s the one that did, obviously, a lot more work.

For Jason, feeding gave him a role—albeit a temporary one since Molly stopped pumping after two months—in his child’s life that made him feel important. Similarly, Pat expressed excitement over being able to feed his daughter a bottle, saying, “I like giving her a bottle
because I feel more involved in the process….I just feel more active in her feeding and development in general. I don’t feel as involved when she’s breastfeeding exclusively.”

Both narratives reveal an underlying belief that the breastfeeding mother is the primary parent and the non-breastfeeding father plays a secondary, less important role (Lupton 2000; Wall and Arnold 2007; Walzer 1998). This belief in the primacy of (breast)feeding as a way to bond with the child and to engage in active parenting may perpetuate inequality in the family division of labor. Jason and Pat also expressed feeling that their role in feeding their children made them central, rather than peripheral, characters, suggesting that feeding both increased their connection with the baby and their sense of importance as fathers in the family. Masculinity involves competition and action19 (Connell 2005; Kimmel 1996; Messner 1997), hence the men’s narratives of feeling active in feeding their baby and important in relation to their female partners (“just as important as she is”) fit with, rather than challenged, dominant norms around masculinity, even as the men expressed the importance and value of being involved parents.

The narratives of participants who described experiencing bonding through breastfeeding stood in stark contrast to participants who expressed disappointment over the lack of a bond they felt through feeding, with some apologizing during the interview for expressing these feelings, revealing that they defy the dominant narrative of breastfeeding. Several women had anticipated that breastfeeding would produce a bond with their baby and that they would enjoy it, but that was not their experience. Ashley said she thought she

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19 I am referring to the gender dichotomy of masculinity as active and femininity as passive.
would “love the breastfeeding time” but found herself feeling impatient as she sat on the couch, breastfeeding her baby throughout the day. She said she “thought it was gonna be like, ahh, so great, such great bonding time, and I do feel that, but it’s not like this, like, ‘Wow, I’m loving this,’ sort of feeling.” Natalie was also disappointed that breastfeeding was not the bonding experience everyone told her it would be. She said sometimes she would breastfeed her daughter “just to pacify her, and it doesn’t make me feel so good.” She thought breastfeeding would create a bond between them, but she said, “I don’t feel that way, maybe that sounds terrible.” Both women were looking for a feeling that they did not get when they breastfed. Ashley’s and Natalie’s hesitancy to express how they felt about breastfeeding—that it wasn’t what they thought it would be—reflects the ideology that mothers should embrace and love the sacrifices they make for their children (Hays 1996). Ashley and Natalie worried about not meeting this standard, fearing judgment from others.

When men described their disappointment with the lack of the bond that feeding produced with their child, their descriptions underscored the ways that men’s participation in childcare is more “optional” than women’s, thus demonstrating how mothers are more constrained by childcare than fathers (Craig 2006). In regard to breastfeeding specifically, mothers are much more constrained than fathers because breastfeeding requires the female body to be present. Yet some narratives also discussed bonding through breastfeeding as biological. Ed linked the lack of bonding he felt with his son through feeding to the difference between male and female bodies, insinuating that if he had the same hormones as women, the feeding would produce a bond. He said:
Part of me wishes that it could really be a bonding thing more than a necessity of, I really just see it mostly as, I don’t want to say chore, but it’s more that (sigh, pause), it’s not a chore or an obstacle, but it’s not really a bonding experience for us as much as I wish it was. I mean, I love the little booger more than I’ve loved any other biped in my entire life, but, I don’t have those automatic hormones going to me.

Ed attributed the bonding of breastfeeding to “automatic hormones” that women with bodies that can breastfeed have and he does not. Yet as Ashley, Natalie, and Desiree all described above, having such hormones does not automatically mean they will feel bonded through breastfeeding. Ed went on to say, “I’m not a part of the real hormone train,” indicating that he experienced his role in feeding—which involved regularly feeding his son with bottles of pumped milk—as somewhat inferior to his partner, Jill’s. Ed said he looked forward to a time when the baby was more interactive and they could “bond through other ways.”

Michael also described feeding as more of a necessity and compared it to holding his son, which of the latter he said felt special and more “optional, recreational.” Feeding “doesn’t feel as special…the feeding is more, he’s hungry and this needs to happen….Obviously, it’s nice to feed him, but it’s, I don’t know, it’s not as special I guess.” Michael described feeding as obligatory—a task to accomplish, he said—and feeling bonded to his son came through other interactions such as “making him smile and laugh…if I can make him laugh, it just makes my day.” Like Pat and Jason who felt “important” by feeding their children, Michael emphasized how bonding with his baby made him feel, placing the emphasis on what it does for the father rather than the baby.
Participants framed breastfeeding as creating a bond with baby, and a few men said they were able to access this bond by participating in the feedings. However, feeding a baby is also part of the routine aspects of childcare: babies need to eat. Previous studies reveal that fathers are more likely to do more of the “fun” aspects of childcare—such as playing and talking with children, which can be done at any time—in comparison to women who do more of the physical tasks that must be done at certain times, such as dressing, feeding, and transporting children (Coltrane 1996; Craig 2006; Lamb 1997; LaRossa 1986; Starrels 1994; Sullivan 2004). Additionally, research with upper-income professional fathers demonstrates that they were more likely to be involved in special events rather than routine childcare (Shows and Gerstel 2009). When women are primary caregivers, and when men’s childcare duties are more optional or recreational than women’s, men’s privilege is reinforced because men are able to choose more freely when to participate in childcare.

As couples anticipated the arrival of their babies, women worried that breastfeeding would preclude men from being able to bond with their baby. In the next section, I outline the mental labor that women undertook in their efforts to include fathers in the bond.

MAKING DADDY A PART OF THE PROCESS

In *Thinking about the Baby*, Susan Walzer (1998) argues that worrying about one’s baby, what she terms “baby worry,” is a part of the invisible, mental labor of childcare. Walzer uses the term “mental labor” in order “to differentiate this less visible work from physical tasks—to capture the internal and interpersonal work that is part of infant care” (1998: 32). “Emotion work” (Hochschild 1983) and “invisible work” (DeVault 1991) are
included in mental labor, so that the term encompasses all the ways that people think and feel about baby care, how people manage how they think or feel about baby care, and how the people who are doing the baby care may not identify it as “work.” When mothers worry about their baby and fathers do not—or, when fathers tell mothers to stop worrying—this reinforces a gendered division of mental labor (Walzer 1998).

When participants framed bonding through breastfeeding as a special relationship between the mother and child, including fathers in this bond became pertinent to many participants. Participants believed that, through breastfeeding, the mother-child bond would likely be closer than the father-child bond, but they wanted to share this bond together and did not want fathers to miss out. One belief about breastfeeding is that it may serve to shut men out of an emotional relationship or bond with their child (Deutsch 1999; Lupton and Barclay 1997). Although both men and women acknowledged this concern, only the women agonized over it and strategized how to overcome men’s potential exclusion before their child’s birth.

Worrying and strategizing how to overcome these concerns added to women’s invisible labor. This was especially notable in the first interviews, when participants discussed their anticipations about how their relationships with the baby and with each other would change after the baby’s birth and because of the mother’s breastfeeding. Within the intimate couple dyad, couples wanted to share the breastfeeding experience with each other because of the bond they believed they would experience.

Participants often expressed feeling anxious or worried about becoming parents, and some men expressed feeling jealous that their wives would be bonding through breastfeeding
with their child. Whereas the women’s emotion work involved attempts at managing their own emotions, as well as those of their partners, men did not try to manage their partner’s emotions, but did discuss their own emotions. Other research contends that men do emotion work on their own behalf rather than on others (Weiss 1990). Some men’s emotion work involved attempts to bring their feelings of anxiety or jealousy in line with culturally acceptable norms of masculinity, essentially following the proper masculine “feeling rules” (Hochschild 1979). For example, Shawn brought up the importance of the mother-child bond through breastfeeding multiple times during his first interview. Toward the end of the interview, I asked him how he felt about not being the one to breastfeed. He said:

I’m a little jealous that they’re gonna share that and I won’t but, (pause) I’m not worried. I’m not scared, ’cause that happens with every kid and I’m close with my dad and I didn’t start making memories until I was like three anyway. So I’m sure I’ll be around for that.

Shawn revealed his feelings of jealousy over the mother-child breastfeeding bond, but at the same time managed his emotions to present a stoic, masculine front by saying he was neither worried nor scared. For the most part, while men expressed their feelings, they did not discuss ways they were trying to change them. For example, Pat said:

Initially, I was thinking if we breastfeed the baby is gonna be closer to her than the baby is to me. But I think that…there are other ways that I will be able to bond with the baby, so I don’t think [breastfeeding’s] gonna preclude my bonding abilities with the baby by any means.
Thus Pat’s emotion work involved suppressing his fears that he would not be able to bond with his daughter as much as his wife would through breastfeeding, and expressing his confidence that he would find other ways to bond with his child.

Women’s narratives, however, revealed that they engaged in extensive emotion work as they anticipated their husbands’ exclusion from the bonding relationship and strategized ways around this dilemma by trying to manage men’s emotions for them. I argue that they did this in two ways: engaging in daddy worry and developing inclusion techniques. The inclusion of fathers in the bonding highlights an aspect of contemporary parenting where fathers are more involved in childcare than in previous decades (Milkie et al. 2009). However, in line with previous studies, my analysis suggests that men were not participating in the mental labor of thinking and worrying about the baby in the same ways as women (Walzer 1998). In what follows, I demonstrate that when women think and worry about how to include men and help the men feel bonded with the baby, they take on added invisible labor.

Engaging in Daddy Worry

Worrying about family members’ well-being is part of the invisible emotion work women do in families (DeVault 1991; Hochschild 1989; Walzer 1998). In Thinking about the Baby, Walzer describes two types of worry work: mothers taking responsibility for the baby (“baby worry”), and mothers questioning whether they are good mothers (“mother worry”). I offer here an additional type of worry work: mothers worrying about the father’s relationship with the baby—what I term daddy worry. This type of worrying is different
from what Walzer describes as women managing their baby’s father, or delegating tasks to the father. I argue that daddy worry is an added component of the mental worry work that new mothers perform. The women in my study actively worked to protect and manage their partners’ feelings when it came to anticipating how the men would feel about the mother-child breastfeeding bond. My findings demonstrate two components of daddy worry: first, women engaged in mental labor (Walzer) as they expressed feeling worried or concerned about how their partners would feel about not being able to bond through breastfeeding, and they engaged in emotion work to both manage how they and their partners were feeling. Second, women described the sense of responsibility they felt for creating—or at least not preventing—the father-baby bond.

First, women engaged in mental labor (Walzer 1998) when they expressed their worries about their partners’ future relationship with the baby. For example, Natalie was certain her partner, Dave, would feel “some kind of let down” over not being able to breastfeed, and she worried about Dave feeling rejected by the baby if he could not comfort the baby. She recalled:

I’ve heard other dads say, “I felt helpless I couldn’t feed my child. I couldn’t take away that crying pain when they were just crying and crying and crying, all they wanted was milk.” And I can only imagine what that must feel like for a dad and then the baby goes to Mom, and baby is happy.

To protect Dave’s feelings, Natalie said she had not shared her worries with him, nor had they discussed the ways he could participate in the feedings. Natalie eagerly anticipated that breastfeeding would produce “mother and baby bonding time” but she was hesitant to share
these feelings with Dave “because he can’t be a part of it really….I just feel he might feel left out and as excited as I am about doing it, there’s a sadness there that he won’t get to partake. It’s kind of back and forth a little bit with emotions.” When I asked Dave at his first interview how he might be involved in the feedings, he said, “We haven’t talked about that. I’m happy to try to be involved however I can, but I guess I don’t know enough to know how I could help.” Thus, when thinking about their future relationships with their daughter, Natalie engaged in daddy worry over Dave’s relationship, whereas Dave did not express any anxiety or concern over how that relationship would develop.

According to Hochschild (1983), emotion work can involve trying to produce a desired emotion in others. Women in my study described undertaking this task. Desiree’s daddy worry involved worrying that her partner, Chris, would feel excluded from the family after the baby’s birth because of the strong mother-baby bond that would result from her breastfeeding. She said:

I think I’m a little worried, and I know Chris was a little worried too, about this kind of setting up the baby and I [to bond], and then Chris kind of over here…. [Breastfeeding] can feel very personal and close and kind of like, “Oh, you’re not needed, Daddy.” And I don’t want him to feel that way.

As Desiree indicated, she planned to “include [Chris] and make [breastfeeding] about the three of us as a unit,” thereby attempting to produce a desired emotion in Chris; in this case, feeling needed.

The second aspect of managing men’s feelings and engaging in daddy worry was evident when the women described the responsibility they felt for creating—or at least not
preventing—the father-baby bond. Previous research documents that a core element of mothering is having a profound sense of responsibility for children (Fox 2009; Hays 1996; McMahon 1995; Ruddick 1995). For example, Allie was highly committed to breastfeeding, but questioned her decision to exclusively breastfeed because she worried it would prevent her partner, Robert, from bonding with their son. She said, “You want to give your husband the same opportunity to bond with the child, but you don’t want to mess your process up,” indicating that she felt responsible for fostering the bond that she wanted Robert to develop with their son, and that the bond should come through feeding. Yet at the same time, Allie struggled to reconcile exclusive breastfeeding with giving Robert the opportunity to feed with a bottle, since it could hinder the breastfeeding relationship. She went on to say:

Part of breastfeeding is bonding, and I want to exclusively breastfeed for six months, you know, I feel, and there’s a part of me that feels really kinda bad about it, because I want Robert to have that opportunity to feed his son because that is a huge part of bonding….I don’t want to give [the baby] a bottle and have nipple confusion, you know, there’s just all these things that you read, and (sigh) I have thought about that a lot, and it really, it tore me for a while….I felt sad about it for a while.

Thus, while Allie revealed her emotion work of managing her own “bad” and “sad” feelings about how breastfeeding would prevent Robert from feeding and bonding with the baby, she also felt responsible for giving Robert the opportunity to feed, and thereby bond, with their son. By taking on this responsibility, her narrative revealed the assumption that she, not Robert, would be the primary parent, not only when it came to the instrumental task of
feeding, but also in terms of taking responsibility and making plans to foster the father-baby relationship (Alby et al. 2014; Coltrane 2000; Deutsch 1999).

In addition to worrying about the father’s relationship with the baby, women also planned things that men could do to develop a bond with the baby through breastfeeding. I now turn to the second aspect of making daddy a part of the process: devising techniques to include daddy.

**Devising Techniques to Include Daddy**

Another aspect of women’s mental labor was devising techniques to include men in breastfeeding, and thereby the bonding. Women believed if men felt included, they would not feel jealous of the mother-child bond. Women also believed that if men participated in feeding and bonding with the baby, they would feel more invested in and responsible for the baby. The “inclusion techniques,” as Natalie called them, involved either pumping breast milk so the father could feed the baby with a bottle,20 or planning ways for men to be present during breastfeeding.

Yet while the men planned to be active and involved in their child’s life—and many anticipated changing lots of diapers—they often had not planned to be directly involved in breastfeeding. Some of them men acted surprised when I asked them in what ways they thought they might be involved in breastfeeding, such as Nick who said, “I don’t know. I

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20 Ironically, as I discussed earlier in the chapter, pumping was not a special or magical experiences. Yet prior to the baby’s birth and participants’ experiences with pumping, participants discussed pumping as a desirable way for women to help men access the breastfeeding bond. Despite the research many women (and a few men) had done, it was not until after they started pumping that they talked about it negatively: particularly, the time it took to pump or the amount of work involved in cleaning the pump parts and bottles.
mean (pause), other than being around, you know, I don’t know.” When I asked Jason what he planned to do while his wife was breastfeeding, he said, “I guess I could just be waiting for them to finish.” Others expressed that they would likely be doing household chores during breastfeeding, such as Brad, who said, “I suspect that I will be cleaning,” and Pat, who said, “I’ll probably be doing other stuff around the house.” Michael anticipated he “might feel a little helpless” because he would not be directly involved in feeding. Thus, the fathers viewed themselves as playing a secondary, peripheral role (Walzer 1998) when it came breastfeeding, reinforcing the mothers’ more primary (responsible) parenting role (Allen and Hawkins 1999).

The most commonly articulated inclusion technique was women’s plans to pump breast milk so that their husbands could bottle-feed the baby with their breast milk and, in this way, be directly included in the feeding, and thus the bond.21 For example, Molly said she planned to pump breast milk, in part so that her partner, Jason, could bond with the baby through feeding: “I’d want my husband, Jason, to be able to feed the baby and stuff like that. I think that’s kind of a bonding experience too.” Holly described the dual purpose of pumping to allow her husband to bottle-feed and thus bond, saying, “I hope Michael doesn’t feel left out [of the bonding] (laughs), but then if I’m also pumping then there can be times that he can bottle-feed the baby, I guess, on breast milk.” Just as Holly worried that Michael might feel “left out,” Natalie expressed how her plans to include Dave in breastfeeding

21 Importantly, formula feeding was never discussed as a way to create a bonding experience, reflecting the participants’ commitments to breastfeeding. Although they had varying opinions on the use of infant formula, breastfeeding was the preferred method of feeding for all participants prior to the birth of the baby. Second best was bottle-feeding with the mother’s breast milk.
stemmed from her desire to help him avoid feeling jealous of the mother-baby bond. She described having read that this could happen “until [fathers] become more included.” She thought Dave would feel “a little bit of jealousy, I don’t think he would ever say anything, but he might internalize that, definitely.” Thus in addition to devising inclusion techniques, Natalie revealed doing emotion work to produce a desired emotion in Dave.

Women also expressed that if men participated in feeding, they would feel “invested” in their children. Thus, including men in feeding was not only about women wanting men to bond with their child, but also hoping that men would develop a sense of responsibility for their child. Eating is mundane because it is something we must do to survive; and yet, the ways we go about eating (and feeding others)—similar to other mundane activities such as sleeping and bathing—are socially constructed. Desiree articulated a notion that feeding their baby with a bottle would help her partner Chris feel “involved” in the baby. “I definitely want [Chris] giving bottles and being invested and all a part of that.” Thus feeding could nurture the special connection with the baby, and this connection could lead men to be more involved and helpful in parenting.

Similar to Holly and Desiree, part of Rachel’s plans for pumping stemmed from her ideas that her partner, Nick, could “feed the child and be a part of the child’s life as much as possible.” Rachel’s narrative also challenged the idea that mothers are naturally more in tune with their children because they are women. When I asked her why she thought it was important for Nick to participate in the feeding, she said:

He needs—it’s important to learn things about your child. I mean, there are some things, even with this dog out here, I spend all day with this dog…I know everything
she’s going to do because I spend all day with her. He comes home in the afternoon and he doesn’t—he’s not in tune to what she’s like or what she needs and he doesn’t know how to talk to her. [Learning about something] starts in the very beginning, and it starts with these very mundane things, like sitting and staring at something and touching something and learning what something is like.

Rachel articulated that becoming an attuned caregiver comes not from innate knowledge, but is cultivated through the time that parents spend with their children, with feeding being a part of that. She recognized that Nick would need to take time to learn about their child just as she would, saying he had not done so with the dog. Rachel hoped that she could foster this learning through giving Nick the opportunity to feed the baby with a bottle.

Despite our physiological need to eat, eating is culturally conditioned, and in our current culture, the “feeding work” (DeVault 1991: 230) of caring for a family and producing the sociability and connection of a family falls to women. Cultural discourses promote breastfeeding as feeding and caring work, and although it does require the female body, as the narratives of some participants and other research (Deutsch 1999) attest, it does not inevitably reinforce men’s privilege and women’s subordination. But given cultural constructs about mothering and fathering and family work in general, it may contribute to family inequalities. Numerous studies have documented how women are more likely to take more responsibility for childrearing than men (e.g., Berk 1985; Bianchi et al. 2000; Bittman 2004; Hochschild 2012; Kan, Sullivan, and Gershuny 2011), and patterns in parenting are often established early on (Aldous, Mulligan, and Bjarnason 1998). Established patterns then appear natural, and become difficult to change. Additionally, following the transition to
parenthood, men’s and women’s attitudes toward the division of labor become more gender-unequal (Baxter et al. 2015). As Holly, Desiree, and Rachel planned to help their partners “invest” in their children, perhaps they were (un)consciously attempting to disrupt early patterns of unequal parenting. Yet the worry work they engaged in and the fact that their husbands were not taking on similar concerns and devising similar strategies suggest that heterosexual couples may find these patterns difficult to subvert, perhaps as a result of being situated in institutions that support a more unequal gender division of labor.

Another inclusion technique that women devised was for men to be present, as much as possible, during breastfeeding, which they thought would help men feel included in the breastfeeding bond. The women’s discussion of this inclusion technique revealed the emotion work that they were doing as they attempted to produce the desired emotion of “feeling included” in their partners. Natalie said she envisioned different things Dave could do while she breastfed based on things she had read or ways he currently interacted with the fetus in utero. Natalie’s plans to include Dave very much revolved around producing a desired emotion in Dave: making him feel like he is participating in breastfeeding. For example, Natalie said that when she is breastfeeding:

I would encourage him to just be with us, whether it be reading her a story while we’re [breastfeeding] or just, you know, holding her hand, just some sort of physical contact with her so that she can hear his voice, I think might make him feel more a part of it. It may not be every time because I know [babies] feed often, especially when they’re super little. But even if we can just do that a few times, or pick the day or pick a time at night time, that’s when we’re going to do our story, and maybe first
thing in the morning, that's when you're going to rub her hand or something like that….Hopefully, if we can include him…and get that routine going, he's gonna feel like he's very much a part of that process, whether the feeding is coming from him or not, he's participating. So I think we can put a positive spin on it by using those inclusion techniques.

Allie’s plans to include Robert were similar to Natalie’s: “We’ll breastfeed in the bed together, and [Robert] can be right there, and look, and be in the same, you know, 12-inch proximity as the child.” Both women’s plans involved the physical closeness of the father to the child during breastfeeding, mirroring the mother’s closeness as she breastfeeds. Although the father will not be breastfeeding, the rationale was that men would feel like their physical closeness would include them in the breastfeeding bond and that this would help assuage men’s fears over being left out.

In sum, women engaged in daddy worry when they expressed worry, concern, or anxiety over the father’s future relationship with the baby, and when they discussed how they managed these feelings and strategized to avoid men’s feelings of jealousy or exclusion. For the most part, women assumed that breastfeeding would produce a special mother-child bond, and they worried about their husbands feeling excluded from the bond. Although men held similar beliefs regarding the mother-child bond, their concern did not lead to plans to participate in breastfeeding. As women worried, they devised inclusion techniques: pumping breast milk so men could bottle-feed and incorporating men physically during breastfeeding. Women undertook mental labor through worrying about how the father would bond with the baby, and took it upon themselves to strategize around this dilemma. These beliefs and
practices can contribute to inequality within families as women strategize how to include men in the breastfeeding bond, leading new parents to engage in an unequal division of mental labor.

However, couples’ experiences with having a baby and breastfeeding were not usually what they anticipated and many families faced unanticipated challenges. How couples responded to such challenges provides insight into the processes involved in protecting the breastfeeding bond that they had long invested in during pregnancy. I found two routes families tended to take when difficulties arose: (1) excluding others by practicing family gatekeeping; and (2) retroactively including others in the bond. My findings show how both strategies underscore the individualized and privatized nature of caregiving within families.

PROTECTING THE BREASTFEEDING BOND: EXCLUDING OTHERS

In their efforts to protect the breastfeeding bond, some families purposely excluded potential helpful outsiders from the caring and feeding processes. These families were strategic and intentional with their actions, fearing that sharing the feeding with others would negatively impact the bond with their baby. Their refusal of help, however, strained the family’s resources, as they withdrew into their nuclear family to maintain and protect the bond. Although breastfeeding is often framed as natural and bonding can be conceived of as a natural outgrowth of breastfeeding, excluding others also underscores the way participants viewed this bond as fragile and in need of defending from outsiders (Blain 1994).
Couples legitimated family gatekeeping by claiming that having a baby was a responsibility that fell to them and them alone. By excluding outsiders in the early weeks and months of parenting, couples also said they relied more on each other, demonstrating their withdrawal behind symbolically-created boundaries. In this section, I highlight Catherine and Shawn’s story to demonstrate how couples practiced family gatekeeping by excluding others in order to protect the breastfeeding bond.

_Catherine and Shawn – “Just back off and let me do what I want to do.”_

For our first interview, I met Shawn and Catherine at a busy fast-food restaurant, although none of us ordered anything to eat or drink. They had come directly from an evening church service, and I got the feeling that Catherine had been eagerly anticipating our meeting while Shawn felt a bit more hesitant. They were both in their late 20s, had bachelor’s degrees, and were working full-time, making around $55K per year combined, until Catherine quit her job at the end of her maternity leave and their income decreased to $32K per year. Catherine was of average height with long blond hair and a deep voice. She laughingly said she had “never been a very girly-girl, never been like super feminine, so [having a baby] for me is gonna be a whole new ballgame.”

After our initial interview, I subsequently interviewed Catherine and Shawn at their home, a two-bedroom rental, which appeared small from the outside—particularly because it was built on the same lot as a massive two-story home—but the inside felt spacious and was decorated with modern colors and Catherine’s photographs. Their two dogs enjoyed my attention and one of them sat on my lap for most of the interview. Shawn was taller than
Catherine and had dark hair and glasses. His comments sometimes came off as abrasive, such as in his second interview when he described bottle-feeding his son. “It’s easy. I’ll just hold him there and shove a bottle in his face and he eats it, or…I’ll say, ‘Eat it.’ And he does.”

Had I not interviewed Shawn multiple times, I would have thought he was frustrated that Catherine had persuaded him to participate in the study based on the brusque and seemingly flippant ways he often responded to my interview questions. However, at the study’s end he said, “It’s been good to reflect on some things; usually I don’t think about this kind of stuff.”

During their first interviews, Catherine and Shawn each spoke extensively about the mother-child bond they believed breastfeeding would produce for Catherine and their son, Jacob, whom they had already named in utero. As I mentioned in the previous section, Shawn felt “a little jealous” about the mother-child bond, but he believed he would find other ways to bond with his son. When I asked Shawn how he thought his relationship with Catherine might change after the baby was born, he said:

I’ll definitely be knocked one down on the totem pole. I’m already below the dogs. I don’t know how much lower I can get (laughs). Sometimes, sometimes it worries me, but not realistically. I don’t think it’ll, I don’t think it’ll change anything. I hope, I hope it gets better. I hope that we can be a unit together and not she and Jacob versus me, like I’m the oppressor, you know? I think it will be fine.

22 In contrast to many participants who assigned agency to their child as I discussed previously, Shawn’s statement framed this moment of the father-son dyad with Shawn, the father, as agentic and Jacob, the baby, as the passive recipient of nourishment.
While Shawn may have been expressing his overall anxiety about becoming a parent, he also revealed some worry about being excluded from an intimate family relationship, reflecting the belief that breastfeeding can shut men out of an emotional relationship or from having a bond with their baby (Deutsch 1999; Lupton and Barclay 1997). Shawn also used the totem pole imagery, stating that his needs were already below their pets in Catherine’s books. Yet he also indicated that if the relationship dynamic was Catherine and the baby against him, he would be the “oppressor,” which is a radically different role than being at the bottom of the totem pole and indeed may signal being at the top if we conceive of a totem pole as a hierarchy.

Shawn seemed uncertain about what their family dynamics would be like after Jacob was born. Here, and elsewhere, his narrative indicated that despite a symbolic depiction of clawing his way into the family—or, into the mother-child dyad—he also relied on Catherine to take responsibility for caring for their son. He stated that Catherine would lead in this regard because it would come naturally to her as a woman and mother. For example, when I asked Shawn if he was doing anything to prepare for breastfeeding, he said:

I haven’t made time to do that and I don’t foresee me making the time to do that…. [Catherine’s] gonna know what she needs to know and if I need to help her with that, if there’s, if she runs into a problem, I’ll certainly do every kind of research I can to figure out what the issue is. But as far as I know, you just put a baby there and it just kinda takes care of itself.

Thus, while Shawn worried about being excluded from a bond with his son, he also was not making any preparations for how to overcome this. Additionally, he was planning to play the
helper role if Catherine had a “problem” with breastfeeding, but otherwise he relied on her to manage the breastfeeding, especially because he assumed it would come naturally to both her and the baby. These types of ideas reinforce gender inequality within families with the assumption that women already “know” how to breastfeed, whereas women’s narratives revealed that they had spent a significant amount of time researching breastfeeding in order to learn about it: reading books and articles, talking to friends and doctors, and taking classes about birth and breastfeeding. While some women do express feeling empowered by their embodied knowledge (Bobel 2002), and it is important not to deny women’s subjectivity, framing breastfeeding as “natural” obscures the work that women do to prepare for a baby and reinforces gender inequality at home.

Catherine also felt very strongly at her first interview that feeding her child would produce a bond between them. She was concerned about what putting the baby in daycare would do to this bond. After visiting potential daycares, she described feeling “really, really, really sad about having to go back to work” and having “super meltdowns.” But she said, “It’s just not affordable for me to not be working.” She hoped to get the baby into a daycare near her work so that she could go there and “breastfeed during the day.” Shawn also said in his interview that he “could be out on lunch and then go to daycare and feed the baby a bottle of pumped milk.” Their narratives before the baby’s birth demonstrated their desires and hopes of being continually involved in breastfeeding, even after returning to work.

But beyond wanting to continue breastfeeding, Catherine was concerned about another person feeding Jacob throughout the day. Catherine made explicit in her narrative that she did not want her sister-in-law, or an in-home daycare worker, to feed Jacob because
of the bonding experience she thought it would produce. Thinking about what daycare might be like, she said:

I’m not so much concerned about the women in the daycare feeding as I have been about, okay if we had to choose a home daycare and it was just one person feeding all the time, that’s when I was kinda like drawing a line, like that may happen but I prefer it not. And Shawn’s sister actually offered to watch our kid like for free…but I just didn’t want that bonding experience [to occur between Shawn’s sister and Jacob]. I mean even though she’s not breastfeeding it’s still like, it just felt like it was too much one-on-one with a family member too, so all day, yeah, I just couldn’t deal with [it].

Catherine felt like her bond with her baby would be threatened if another person, especially a family member, was responsible for feeding her child while she was at work. Even though Shawn’s sister offered them free childcare, excluding her from the bond was more important to Catherine than the cost of childcare, which she knew would be a financial burden. Her concern for protecting the breastfeeding bond superseded her financial concerns.

In the third interview, Catherine gave an elaborate account of the process of deciding to quit her job and become a stay-at-home mom. She pointed to the high cost of daycare as a reason to quit her job, despite Shawn’s sister’s continued offer of free childcare for Jacob. Another reason Catherine gave for quitting her job was her desire to continue breastfeeding. Beyond protecting the bond created through breastfeeding, Catherine’s narrative suggested she was also fearful about the quality of care only she could offer Jacob. Thinking about returning to work, she recounted, “I just didn’t feel good about it at all. I mean, obviously,
people don’t feel good about it because you don’t want your baby at daycare or even with, even if it’s with like your mom or sister, you still just feel uncomfortable because you’re not with that baby.” Here, Catherine reinforced the dominant ideology of intensive mothering (Hays 1996): the mother should be the child’s primary caregiver and this should take precedence over her career aspirations. Additionally, the way Catherine made this statement, using the word “you,” transformed this into a broader statement about women. Caring for one’s own child was not just what Catherine should do, but what women in general should do, a belief that reinforces gender inequality more broadly.

Shawn and Catherine engaged in family gatekeeping, choosing to rely on themselves and their own resources for, in this case, childcare and support. When I asked them during the third interview about the ways people could have been supportive of their family during their transition to parenthood, Shawn said:

I kind of went into it with an understanding that it was going to be, this is our responsibility, burden’s a strong word, but I mean, it’s on us. You know, it’s on us to deal with the issues that come up and to work through it and figure how it works and that kind of stuff. I wasn’t really expecting a lot of support from other people.

Additionally, Shawn noted the importance of others not giving them unwanted suggestions or advice about breastfeeding. He said: “If I want to breastfeed my child, then I’ll do that. I don’t want to hear any suggestions about how I should be doing it differently or giving him a bottle….Just back off and let me do what I want to do.” Shawn protected the breastfeeding bond through family gatekeeping by stressing both their financial responsibility over their nuclear family, and their detachment from the assistance and advice friends and extended
family members offered or might have provided. Pugh (2015) suggests that one emotional response families have developed to deal with the current “insecurity culture”\(^{23}\) is to stress the nuclear family unit, their independence and self-reliance, and their detachment from others. Shawn’s disregard for his family’s offers of support and advice underscores Shawn’s belief in self-reliance and personal responsibility.

While Shawn’s sister offered free childcare for Jacob, Catherine and Shawn practiced family gatekeeping by refusing her help, and thus excluded her from creating a bond with Jacob. As Shawn said, “it’s on us” to figure out how to manage their family life. And they did. With the loss of Catherine’s income, bringing their annual income down from around $55K to $32K, Shawn started working for his father’s landscaping business on Saturdays, increasing the days he spent working from five to six days a week.\(^{24}\) This resulted in Shawn being away from Catherine and Jacob more often, putting an increased burden of childcare on Catherine. Shawn lamented, “I feel bad that I can’t be here to help with the schedule, with our routine, and get him to sleep because that’s a lot on her.” Yet for them this arrangement was preferable to Catherine working and someone else feeding (and thus bonding with) their baby.

Catherine and Shawn’s story helps to build our understanding of the processes involved in family gatekeeping in several ways. First, Catherine’s narrative about excluding

\(^{23}\) Pugh defines insecurity culture as “a culture of personal responsibility and risk, linked to the spread of precariousness at work, the neoliberal receding of the state, and the dominance of the market” (2015: 4).

\(^{24}\) By working for his father’s company, Shawn did in a way rely on his family, yet not in a way that involved caregiving for their son. When I contacted Shawn and Catherine for their one-year follow-up, Catherine said that Shawn had been hired at a new job in a different city, so they would be moving and he would no longer be working for his father.
her sister-in-law or an in-home daycare worker from caring for the baby because of the ways it would threaten her bond with her son reinforces the ideology of intensive mothering (Hays 1996). Second, Shawn’s narrative about their responsibility as parents and not wanting the input or help from others highlights the individualized and privatized nature of parenting. Their reliance on each other rather than on outside support, as well as their purposeful exclusion of others, placed financial and emotional burdens on their family, which they strategized to resolve. Yet Catherine stated at the third interview about their decisions: “I cannot imagine, like, any other way.” They framed their decisions as doing the best for their family.

PROTECTING THE BREASTFEEDING BOND: INCLUDING OTHERS

Whereas some couples who faced challenges with their new baby practiced family gatekeeping by excluding potential helpful others and thereby protecting the bond, other couples accepted help that was offered from outsiders, most often family members. Unlike the families who purposely and strategically excluded others from the bond, families who included others did so in unplanned ways. These families experienced a challenging situation with their new baby, and accepted the help of others outside the couple dyad. These outsiders were intimately involved in the family, taking on a lot of childcare and feeding in the early weeks of the baby’s life, as well as offering emotional support to the family. In order to protect the breastfeeding bond, families had to reframe their situation to include the outsider in the bond so that the outsider’s participation would not threaten the bond. Effectively, the outsider became elevated to the status of a parent for a short period of time.
Yet, this process was retroactive because the need was so immediate, and it was not until later, as the family reflected on their situation, that they were able to frame how the outsider was included in the bond.

Although this strategy is different from excluding others from the bond, I argue that it too underscores the individualized and privatized nature of caregiving, as families drew upon their private resources to solve their problems. Below, I highlight Desiree and Chris’s story of how Desiree’s mother was involved in the early weeks of childcare, and how they retroactively included her in the bond with their baby. Desiree’s mother spent a significant amount of time with the family and took on much of the parenting labor. Her ability to participate in the family was a social capital resource that Desiree and Chris were able to access. In order to help Desiree and Chris, she was in apparently good enough health to stay awake at night, and had a large amount of free time, despite her own spouse and home, and other grown children and grandchild(ren). She was not in the paid labor force, thus was not constrained by a job’s schedule. She stayed awake for hours at night, and then would return to her home and sleep during the day. Although such help is available for hire, such as a post-partum doula (which Desiree also hired to help with some household chores), Desiree and Chris were able to capitalize on her mother’s free labor, which gave the couple time to sleep, gave Desiree time to pump, and provided additional emotional and instrumental support for the family. Retrospectively, Desiree and Chris discussed the value of her mother’s contributions, as well as the value of including her in the bond.
Desiree and Chris – Breastfeeding is “a six-hand job.”

I first interviewed Desiree and Chris via video-chat because I was trying to squeeze in their interview before I went into labor with my second child. I later interviewed them in their home: a relatively new, large, two-story home with an open-concept downstairs, granite countertops, high ceilings, and a double-car garage. Desiree and Chris were both in their mid-30s. Chris had a bachelor’s degree and worked as an actuary. Desiree had recently finished her PhD and worked a permanent part-time position as a counselor. Together they made about $230K, making them the highest income earners in my sample. Chris was tall with dark hair and glasses, and I attributed his slender physique to his love of running. Desiree also had dark hair and a warm smile. After the baby’s birth, she was anxious to shed the pregnancy weight she had gained, describing herself as “definitely not the young bright thing that I used to be,” and struggled to balance being gentle with herself with not being frustrated or angry with her appearance. I found that Desiree and Chris were both easy to talk to, and they were reflective about their own lives and experiences, often providing detailed accounts of situations without much prompting.

Desiree’s mother, a homemaker who lived nearby with her retired husband, was one of myriad resources Desiree and Chris had at their disposal. She began coming to their house to help with their baby, James, shortly after they returned home from the hospital. Desiree and Chris were extremely sleep-deprived after James’s birth. Added to this, Desiree described experiencing emotional and physical agony from early difficulties with breastfeeding. They took James to an Ear, Nose, and Throat (ENT) doctor who diagnosed James with a short tongue, which the doctor said affected his ability to latch and breastfeed.
With the help of a private lactation consultant, Desiree tried to get James “back to the breast.” But after trying to breastfeed for another week, Desiree said, “He was just not having it,” which led Desiree to the decision to pump exclusively. As I mentioned earlier, Desiree assigned a lot of agency to James, which may be a strategy to repudiate mother-blame. Yet Desiree still felt somewhat like a failure. By exclusively pumping, Desiree was acutely aware that she had taken a feeding route that was “definitely not the norm,” and described struggling to find resources about pumping “like it’s a dirty secret or something,” “kind of like this shady side-corner thing, it was kind of like a black sheep, that’s how it very much felt in the beginning. Like I wasn’t good enough to breastfeed or I couldn’t figure it out.” Although she expressed pride in her ability to produce breast milk for James through pumping, she also felt judged by other women for not breastfeeding. This reveals the pressure she felt to conform to ideal motherhood (Hays 1996) and her belief that she had failed at something that was supposed to be inherent to her as a woman.

Desiree’s mother became intimately involved in the daily (and nightly) routine care of James, but also provided emotional family support. Chris recalled during the second interview that Desiree’s mother “stayed the night a couple [of nights]” and gave them “four-hour shifts of sleeping.” He said that a few times she “bit the bullet and just watched him all night so both of us could get sleep.” Desiree said her mother was “practically living with us” for three weeks and described their nightly routine as follows: “Chris would be up with the baby until 1:00 or 2:00 a.m., I would get up and pump, and then I would get my mom up and my mom would be with him from 2:00 to 6:00 a.m.” Chris said that having Desiree’s mother around was “very helpful” not only in terms of “another pair of hands with Desiree and the
pumping” but also because she was a “very calming presence” during an emotional and exhausting time. Desiree’s mother also helped with the laundry, cleaning, and making them food. Desiree described in her second interview that several weeks into parenting, Chris and her mother encouraged Desiree to see a counselor: “I really just completely lost it and tears and all over the place, and that’s when Chris and my mom sat me down and were like, ‘Desiree, this isn’t sustainable, like you can’t keep doing this, you can’t keep punishing yourself for [not] breastfeeding or whatever.’” Desiree’s mother not only provided instrumental support, but emotional support as well.

Desiree framed her mother’s involvement as not only a positive thing, but also as an essential member of the parenting team. Unlike Shawn and Catherine, who framed doing parenting by themselves as critical for their family, Desiree said she enjoyed “being able to share the [feeding] responsibilities with friends, with family.” In fact, Desiree reframed their situation as more advantageous than if she had breastfed, because of the ways that James was connected to his grandmother and other extended family members. Desiree described how “James was able to get fed by my mom, by Chris, by other family members” and framed this as a way to foster his connection with those outsiders. “I want him to be connected to me, of course. But I also want him to feel very comfortable with a lot of other people, especially immediate family members. So [feeding is] a nice way to kind of foster that.” Here too, Desiree described the family members who were outside the nuclear family as “immediate” family, rather than extended family, indicating the closeness she herself felt to them. In the end, Desiree believed that for their family, pumping “was a good thing” and “had some advantages over breastfeeding,” such as “Chris being able to be more involved and my mom
definitely got closer with James as a result, than she has with her other grandchildren.”

While Desiree saw this closeness between her mother and James as a positive thing, it could also be problematic for the family because she suggested that James received a benefit that other grandchildren did not. Other research demonstrates that mothers are more likely to provide emotional and instrumental assistance to their daughters than their sons (Suitor, Pillemer, and Sechrist 2006), and Desiree’s description suggests that she received a maternal benefit that her brothers did not.

As I stated above, Desiree was acutely aware of judgment from other women because she chose to pump, but she did not express feeling judged about accepting help from her mother. Yet the narratives of other participants suggested there is a good deal of judgment around parents, and especially mothers, needing help. Allie, a participant who practiced family gatekeeping, expressed her disdain for needing help with her baby, saying “You have to be a certain type of person to just allow somebody to come and just take care of your kid for you…no one just comes in and does it for you.” I did not directly ask Desiree if she felt judged by others because she needed her mother’s help, but it may be that by reframing the situation to include her mother in the bond and thus expand the bonding unit, she was also seeking to deflect any judgment: proclaiming that what she had done was actually beneficial, rather than detrimental, to James.

While Desiree did not talk in her interviews about feeling judged for accepting help, she did discuss the identity work she had to do to build her identity as a mother because she was pumping, rather than breastfeeding, and because she was receiving so much help from her mother and Chris. When her mother would go home during the day, and Chris was at
work, Desiree said this was the time she had to “build my confidence” with James because “it felt for a while like everyone else was taking care of him and I was just pumping. And that was my worth as a mother.” Thus doing the routine aspects of childcare were central to Desiree’s mothering identity, and it was not until she spent time alone with James that she described feeling like a mother. Spending time alone with a baby gives mothers and fathers the space to develop a sense of responsibility for their child, which is often positioned as a core element of mothering (Fox 2009; Hays 1996; McMahon 1995; Rehel 2014; Ruddick 1995). Desiree’s statement demonstrates how developing that responsibility is not innate, rather it was experienced as something that needed to be learned and practiced. Far from doing parenting on her own, Desiree felt like at first, she was not doing any parenting. In her third interview, Desiree described how James’s transition from an in-home nanny to a daycare helped build her confidence even more. She said, “Even with the nanny here, I still felt like there’s some other expert on my child involved,” whereas once James was in daycare she felt like “I know what’s best for my particular child…out of everyone who thinks they know what he wants, I really know.” Interestingly, Desiree’s feelings about the nanny being an “expert” on her child were similar to Catherine’s fears about another caregiver bonding with her baby. While Desiree was unable to draw on breastfeeding to affirm her identity as a mother, she articulated the significance of taking care of her child, providing him with breast milk, and spending time alone with him which ultimately made her feel like an expert on her child and affirmed her identity as “a really, really good mom.”

In sum, unlike participants who practiced family gatekeeping by intentionally excluding others from the breastfeeding bond, Desiree and Chris retroactively included
Desiree’s mother in the bond, which they then stated helped to protect, preserve, and extend the bond. They reframed their situation to demonstrate how their choice was what was best for their baby and their family. Yet Desiree said this came at a cost to her mothering identity. It was not until the outsiders—namely, her mother and the nanny—were no longer involved in James’s childcare that she fully felt like a good mother. Additionally, both strategies of excluding and including outsiders relied on utilizing a family’s private resources to cope with their individual situations, which underscores the individualistic and privatized nature of caregiving.

CONCLUSION

In this chapter, I focused on the idea that bonding with baby through breastfeeding is framed as a special practice, separate from other mundane practices of childcare, including pumping. Breastfeeding literature emphasizes the special bond that mothers can nurture with their child through breastfeeding and, as the participants’ narratives from their first interviews attest, this was an ideal that many hoped to achieve. Yet as the women and men experienced breast and infant feeding, their experiences sometimes differed from their original plans. Participants described the physical and emotional attachments to the baby that breastfeeding created, as well as the baby’s agency in feeding, ideas that contributed to framing the bond as something special. Other women did not feel this same physical or emotional connection with their baby through breastfeeding, yet to preserve the ideal, they continued to work at it. Some men also connected to their children through participating in the feedings. In order to protect the bond, and their identities as parents, some families
practiced family gatekeeping by excluding others from helping with their child, whereas others accepted help from outsiders who became retroactively included in the bond. Overall, I argue that these families’ practices unconsciously reproduce inequality within and between families, as their narratives of doing the best for baby obscure the larger social problems of gender-unequal parenting, access to choices about breastfeeding, and the moralization of breastfeeding. As women engaged in daddy worry and devised inclusion techniques for men to be involved in the bond, they took on a managerial role that increased their invisible, mental labor. The men’s narratives often indicated that they did not know their wives were doing these things, reinforcing the invisibility of the labor. Yet the women, through their worry, thought they needed to do these things or else the men would not be able to bond with their child. In these ways, this aspect of their relationship reflected a manager-helper dynamic (Alby et al. 2014; Allen and Hawkins 1999; Blain 1994; Coltrane 1989, 1996; Deutsch 1999; Ehrensaft 1987; Ferree 1991; Hays 1996; Mederer 1993; Rehel 2014), as wives took on responsibility for orchestrating ways husbands could bond with babies. This reinforced an unequal division of mental labor between couples, even among couples who otherwise were preparing to adopt more egalitarian, co-parenting roles.

Additionally, inequality is reproduced between families as families in socially privileged positions use their resources to make privatized and individualized decisions, such as family gatekeeping. Breastfeeding, which can be conceived of as a part of intensive mothering (Hays 1996), has become a moral issue and a moral imperative (Wall 2001): good mothers choose breastfeeding. Yet not all women and families have access to this choice, as it requires women to have a lot of time and exude a lot of effort to make it work. Although
breastfeeding is often framed as natural, my participants spoke extensively about learning to breastfeed under the instruction of lactation consultants in or out of the hospital. Families with fewer financial resources are less likely to be able to afford the services of a private lactation consultant or a post-partum doula. And although most couples tout the free aspect of breastfeeding, compared to infant formula, they do not consider the cost of women’s breastfeeding labor in terms of being attached to a baby for hours each day. Many women do not have the freedom to take the time to breastfeed or develop a breast milk supply through pumping if they plan to return to the paid labor force. My participants consistently framed that they were doing what was best for the baby, or for their family, but the things that made it possible for them to do the best—their access to resources, high incomes, steady paid jobs, high education, partners, family, support—are individual solutions to a larger, social problem of the devaluation of childcare.

However, these families’ stories also demonstrate the needs new parents face and the types of support that are likely to be beneficial. On an individual level, couples may benefit from talking together before the baby’s birth—and continuing those conversations after the birth—about ways they might bond with their baby, how they feel about breastfeeding, and ways they might encourage each other’s relationships with the baby. These types of conversations may help alleviate women’s mental labor. Family counseling may be useful to expectant and new parents as they experience anxiety over the changes in their family.

On an institutional level, families would benefit from longer (paid) maternity and paternity leave. Research demonstrates that when fathers’ leave from work is structurally similar to mothers, they are able to experience the routine aspects of childcare, take more
responsibility for their children, and move from a being helper to a co-parent (Rehel 2014). The U.S. is far behind other countries in terms of offering parental leave, as the U.S. does not mandate any leave, paid or unpaid, for new parents (Livingston 2016). Additionally, many countries that mandate parental leave also allot specific time for paternity leave (Livingston 2016). If we want to be a society that promotes breastfeeding specifically, and families more generally, government and employer support through paid leave for mothers and fathers—and caregivers more generally—would be beneficial. Families, regardless of income level, would also benefit from access to high quality medical care and lactation consultants, should they want to breastfeed and encounter breastfeeding difficulties.

On a broader cultural level, we would, of course, benefit from greater gender equality. Although researchers document a “stall” in gender egalitarian ideals, especially among young men (Cotter, Hermsen, and Vanneman 2011; England 2010; Thebaud and Pedulla 2016), young men are more likely to support progressive work-family policies if they believe the majority of their male peers also support these gender-progressive arrangements (Thebaud and Pedulla 2016). Thus, in addition to needing structural support for families such as paid leave, cultural norms are powerful in influencing how structural supports are created, perceived, and used by people. Additionally, women continue to face cultural and interpersonal judgment for not meeting ideal mothering standards (Hays 1996). We must keep in mind the persistence of powerful gender norms as we work to change those norms, and aim to make policies that promote gender equality, a point I will return to in the concluding chapter of this dissertation.
As parents struggle with decisions regarding who will care for their children in light of myriad structural constraints, such as inadequate resources for childcare and lack of mandated parental leave, I hope that we will work toward a cultural shift where caring for others—children, the elderly, the disabled—is a valued position, and that the value of caregiving is reinforced through structural and financial supports for all families. Humans are social beings who need touch, nurturance, and love. Feeding a baby—by breast or bottle—is one way to meet this need at a very early stage, and we would do well to support and recognize those who do this work.
CHAPTER 5

“IT’S EASIER JUST TO DO IT MYSELF”:

GENDERING THE DIVISION OF LABOR DURING THE FOURTH SHIFT

The biggest thing is [Robert] goes to work so that I don’t have to, you know, and to me that’s all he should have to do, is go do that, so I can stay here and do this job, ’cause they’re both full-time jobs...there’s no letting up. But he is good, like every once in a while I’ll ask him in the middle of the night to change a diaper or something like that and he never says no, so, that’s good. — Allie, second interview

INTRODUCTION

In interviewing parents shortly after the birth of their first child, they repeatedly raised the issue of sleep deprivation. Almost everyone was tired, and almost everyone was surprised at the work it took to care for a newborn around the clock. New parents had not anticipated the toll that sleep deprivation would take on their moods and relationships with one another. Additionally, couples had a new type of labor to contend with: childcare. Couples made negotiations—often implicitly—when it came to the division of childcare labor, both during the day and night. As Allie indicated in the above quote, she and Robert divided the paid and unpaid labor, with Robert “go[ing] to work” so that Allie “can stay here,” at home, and care for the baby. For many couples, this division of labor carried into the night. Although some fathers woke up consistently with their babies, others, such as Robert, changed a diaper “every once in a while.” In this chapter, I analyze couples’ narratives regarding the division of labor during the night, and illustrate how they constructed men’s paid labor as the most valued type of work, while they devalued not only the unpaid work of childcare—typically the responsibility of women—but also women’s paid labor.
As I outlined in chapter one, for heterosexual married couples the birth of a first child is a key moment in the division of household labor, often leading to gender-unequal practices (Baxter et al. 2015; Bianchi et al. 2000; Calasanti and Bailey 1991; Cowan and Cowan 1992; Craig and Powell 2011; Gjerdingen and Center 2005; Sanchez and Thomson 1997; Shelton 2000; Walzer 1998; Yavorsky et al. 2015). Additionally, some research finds that these unequal practices reflect a manager-helper dynamic wherein women take on managerial roles and men take on helper roles (Alby et al. 2014; Allen and Hawkins 1999; Blain 1994; Coltrane 1989, 1996, 2000; Deutsch 1999; Doucet 2001; Ehrensaft 1987; Ferree 1991; Gerson 1993; Hays 1996; Mederer 1993; Rehel 2014). In this chapter, I focus on how family care work of the second shift and family emotion work of the third shift (Hochschild 1989, 1997) continue in the night, what scholars term the “fourth shift” (Venn et al. 2008). I demonstrate how women may come to take responsibility for managing and caring for the emotional and practical needs of family members during the night. My research contributes to scholarly work on the manager-helper dynamic by extending it to the fourth shift of sleep care and management. I found that manager-helper couples \((n = 7)\) justified their gender-unequal division of labor in the fourth shift in two ways: privileging men’s paid labor over women’s unpaid childcare labor, and accounting for men’s lesser involvement on the basis of biological justifications, thereby naturalizing women’s greater and men’s lesser involvement in the fourth shift.\(^{25}\) Moreover, these justifications began prior to the baby’s birth and continued until the baby was at least six months old, even after five of the seven women in

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\(^{25}\) While seven out of 12 couples clearly adopted the manager-helper dynamic, three other couples displayed some elements of the manager-helper dynamic but did not as clearly exemplify these roles. See Table 5 on page 135.
manager-helper couples returned to paid employment, demonstrating how early negotiations of gender-unequal childcare labor may establish later patterns and practices.

Overall, I found that among the manager-helper couples, women became the guardians of men’s sleep by taking responsibility for the labor of the fourth shift and subjugating their own need for sleep. Couples used paid labor and biological justifications for why men should do less and women should do more. Men were often complicit in these arrangements and rarely resisted women’s management. Couples privileged men’s need for sleep because of men’s quick return to paid labor, and while many discussed the amount of effort and energy it took to care for a baby, women’s need for sleep to accomplish this work was disregarded. Biological accounts that naturalized women’s greater and men’s lesser roles in care—especially nighttime care—reinforced gender inequality. Couples’ unequal division of labor continued past women’s leave from paid employment, as couples’ arrangements were often unspoken and rarely renegotiated. When couples privileged men’s sleep, they devalued women’s childcare labor, which became literally invisible to the men who slept through it.

In what follows, I first describe how the manager-helper and sharing divisions of labor emerged in couples’ narratives. Then, I discuss how these divisions continue into the night and review literature on the sociology of sleep. Second, I discuss the importance of sleep and describe the lack of explicit negotiations that contributed to couples’ nighttime care arrangements. Third, I discuss what I uncovered about the processes that underlie the gendered division of nighttime labor: privileging men’s work and sleep, and using biological
justifications for men’s lesser and women’s greater involvement in care. I conclude by
drawing out the implications of these findings.

MANAGER-HELPER DYNAMICS AND THE FOURTH SHIFT

As I analyzed the narratives of the couples in my study, I found that many of them
came to divide childcare in unequal ways. For the most part, women became the managers
and men became the helpers. To briefly reiterate chapter one’s discussion of the manager-
helper dynamic, managers notice when a chore needs to be done and make sure someone is
adequately doing it (Coltrane 1989). The key to understanding the manager role is the
responsibly that it entails. Managers feel ultimately responsible for the labor or care.
Helpers wait to be told what to do, when to do it, and how it should be done (Coltrane 1989).
Additionally, managers are the ones who accomplish the mental labor involved in the tasks
(Walzer 1998), meaning that even in cases where helpers may do more tasks than managers,
helpers are not responsible for the planning, implementation, or completion of the tasks
(Alby et al. 2014; Daly 2002; Doucet 2001).

To analyze how couples divided childcare, I coded the data with an eye to who did
what, but also to the ways couples talked about how family labor was deliberated and
coordinated. Codes for how couples divided childcare that coalesced into the concept of
“manager” care involved terms such as “supervision,” “my system,” “asking him to do it,”
and “bossy.” The concept of “helper” involved codes such as “helping,” “she lets me,” “not
responsible,” and “giving support.” Couples also talked about ways they shared childcare.
The category “sharing” involved codes such as “team,” “pair,” and “we decided.” Although
none of the couples had fully egalitarian arrangements, some couples’ narratives contained
more examples of sharing than of managing and/or helping. While couples’ narratives were
complex, I categorized couples’ divisions of childcare in terms of manager-helpers (the most
common arrangement), some sharing, and mostly sharing (the least common arrangement)
(see Table 5).
### TABLE 5: Division of Labor and Feeding Strategy

<table>
<thead>
<tr>
<th>Name</th>
<th>Occupation at T1*</th>
<th>DOL</th>
<th>Feeding Strategy at T2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allie</td>
<td>Esthetician (PT)</td>
<td>some manager-helper, some sharing</td>
<td>mostly breastfeeding, some formula, some pumping</td>
</tr>
<tr>
<td>Robert</td>
<td>Insurance Agent</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Andrea</td>
<td>College Instructor</td>
<td>manager-helper</td>
<td>exclusive breastfeeding</td>
</tr>
<tr>
<td>Josh</td>
<td>Civil Engineer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ashley</td>
<td>Post-doc</td>
<td>manager-helper</td>
<td>breastfeeding, formula, pumping</td>
</tr>
<tr>
<td>Pat</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Catherine</td>
<td>Clinical Trial Assistant</td>
<td>manager-helper</td>
<td>exclusive breastfeeding, some pumping</td>
</tr>
<tr>
<td>Shawn</td>
<td>Project Manager</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Desiree</td>
<td>Counselor (PT)</td>
<td>some sharing, some managing</td>
<td>exclusive pumping, other human milk, some formula</td>
</tr>
<tr>
<td>Chris</td>
<td>Actuary</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emily</td>
<td>Student</td>
<td>mostly sharing</td>
<td>mostly breastfeeding, some pumping</td>
</tr>
<tr>
<td>Brad</td>
<td>Law Student</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Holly</td>
<td>Graduate Assistant</td>
<td>manager-helper</td>
<td>mostly breastfeeding, some pumping</td>
</tr>
<tr>
<td>Michael</td>
<td>Software Engineer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Jill</td>
<td>Graduate Assistant</td>
<td>mostly sharing</td>
<td>mostly breastfeeding, some pumping</td>
</tr>
<tr>
<td>Ed</td>
<td>Psychologist</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Michelle</td>
<td>Professor</td>
<td>manager-helper</td>
<td>breastfeeding, pumping</td>
</tr>
<tr>
<td>Graham</td>
<td>Software Engineer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Molly</td>
<td>Middle School Teacher</td>
<td>some sharing^26</td>
<td>mostly pumping, breastfeeding</td>
</tr>
<tr>
<td>Jason</td>
<td>Financial Analyst</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Natalie</td>
<td>Substitute Teacher (PT)</td>
<td>manager-helper</td>
<td>mostly breastfeeding, some pumping</td>
</tr>
<tr>
<td>Dave</td>
<td>Insurance Manager</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rachel</td>
<td>Writer</td>
<td>manager-helper</td>
<td>mostly breastfeeding, pumping, other human milk</td>
</tr>
<tr>
<td>Nick</td>
<td>Electrical Engineer</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

^ = full-time unless otherwise indicated

26 Molly and Jason’s specific situation made their case somewhat unique and therefore I struggled to categorize their division of labor. Their baby was only two weeks old at the time of our interview, and had spent almost one week in the hospital. They had been home with the baby about a week, Molly was mostly pumping and beginning to breastfeed, and Molly’s mother was living with them to help with the baby. Molly’s mother took care of most of the fourth-shift labor in the early weeks. At our third interview, they had moved and were living with Molly’s parents, providing more adults to help with the childcare. They talked about not “keeping score” of who did what and the ways their work “equaled itself out.” Yet because Molly said she was the one waking up at night to feed the baby, I categorized them as doing some sharing.
Manager-helper couples’ divisions of childcare generally entailed women doing the managing and men taking their cues from women. These couples’ narratives indicated that women took responsibility for the baby’s care, whereas men followed women’s cues. This arrangement was not without conflict. In their second interviews (conducted separately), Michelle and Graham each discussed some of the conflicts they had experienced around who did what and how it was coordinated during the first few weeks after the baby was born. In speaking of their division of labor, Michelle said she didn’t “want to feel like I’m ordering [Graham] around.” Graham, however, described feeling like “a gopher,” saying, “I feel like I’m being told to do things or bossed around or something.” Graham said he felt frustrated, for example, when Michelle would ask him to pick up items from the store for the baby, and then would tell him he got the wrong brand or went to the wrong store. Their compromise in this instance was that Michelle would pre-order items and Graham would pick them up.

“[Now] if she really wants some particular brand or something, she’ll go…online and place an online order, so they’ll have it available for pickup [at the store]. She’s not sending me to try to find it and hope that it’s on the shelf and stuff like that.” This is one example of how couples came to enact the manager-helper dynamic, with women choosing products, sometimes after having done research, and men helping by getting the items without the responsibility of making any decisions about the products or even, in this case, of locating them on the shelves.

27 The one exception to this was Desiree and Chris. They ended up doing more sharing of the feeding work because they did exclusive bottle-feeding; however, they were also the only couple who gave a few examples of how the husband managed some of the care.
Within manager-helper couples, men relied on women to instruct or direct them about how to care for the baby. During Natalie’s second interview, she and Dave had an exchange that illuminated this dynamic. During the interview, Dave was taking care of the baby, Emma, who became fussy and began crying. About an hour into the interview, Dave entered the room and he and Natalie had the following exchange. The exchange also demonstrates that Natalie had been researching infants’ patterns and needs in an effort to learn how to do childcare:

Dave: I think she’s hungry.

Natalie: She can’t be hungry. She fed [not long ago]—well this is just what I was reading, was like to hold her in a different way because if it’s been like less than a certain of amount of time, it could just be fussiness and not necessarily hunger.

Dave: Okay.

Natalie: Because when I went back upstairs I’d already fed her on both sides for 40 minutes.

Dave: Okay, all right. (walking away)

Natalie: I’m just saying, I just read that today about the pumping.

Dave: Okay, we’ll go consult. (leaves room)

Laura: If you need to stop or whatever, it’s fine. Just let me know.

Natalie: We’ll see how much she screams but I, what time is it? She shouldn’t, she really shouldn’t—. (calls out—baby screaming in background) Did you check her diaper? He probably can’t hear me, that’s fine.

Natalie not only demonstrated that she had done research on other strategies she and Dave could use ("hold her a different way" or "check her diaper") to calm fussy Emma, but also that she was the one keeping track of feedings in terms of how recently the last feeding was
and how long it had lasted. A few moments later, Natalie referred back to the above exchange:

The first few days [after Dave went back to work] he kept saying kind of like he did right now, “I think she’s hungry.” It’s like, *(exasperated sigh)* she just ate, you wouldn’t know that, though, because you go to the office, but she literally just ate. I sat here for 45 minutes and I fed her. That’s how I know she just ate. We’ve been trying to get better at [how we say things]...so instead of saying, “I think she needs to eat,” which really just says, “I think it’s time for you to sit down and stop what you’re doing and here you go,” which is how I’m internalizing it. I know it’s not how he means it. To say, “She’s kind of fussy and is there anything you think I should do?” kind of, looking for me to say, “Well, maybe she’s hungry.”

Natalie’s narrative indicated that she and Dave had worked to change how they say things to avoid overt conflict, which was a common theme across interviews, yet the substance or implications of the conversations had not changed dramatically. Natalie did not want Dave to simply propose that Emma was hungry but rather to ask for suggestions about what he could possibly do to soothe her, although Natalie suspected that what he really wanted was for her to say that the baby was hungry and take over. Either way, it was clear that Dave was taking cues from Natalie. Also clear was Natalie’s frustration that Dave seemed oblivious to the childcare she was doing. Natalie implied that she wanted Dave to ask her why she thought Emma was fussy, rather than tell her that Emma was hungry. While this reveals the power Natalie had over decisions regarding Emma’s care, it also may indicate a dynamic of hidden power (Lukes 2004; Tichenor 2005) given that neither Dave nor Natalie thought Dave
should take the initiative in caring for Emma. His paid work trumped his involvement in childcare. This assumption allowed Dave to avoid being involved in ways he did not want to be.

Couples categorized as sharing some or most childcare talked about ways they shared or divided responsibility for childcare. For example, in her second interview, Emily described how Brad was responsible for changing the baby’s diapers, and how he took responsibility for the baby while Emily went to class:

[Brad’s] changed like 99 percent of [Ava’s] diapers since she was born. I don’t think I changed a diaper for the first week. He was doing it. He was doing absolutely everything. We [went] to the birthing center for the two-week check-up and they were like, “How many diapers do you change in a day?” and I was like, “Don’t ask me, Brad does all of that stuff right now.” And then he’s been taking me to class and being with her while I am in class and trying to find things to do [with her].

Like Brad and Emily, who made plans to share childcare even before the baby was born, Desiree and Chris had a prenatal plan for how childcare would be divided. However, their plan largely involved Desiree taking responsibility for infant care and Chris “taking care of everything else.” Ultimately, they said they ended up sharing a lot more childcare responsibilities than they anticipated. They accounted for this by saying that Desiree was not breastfeeding (and instead exclusively pumping) and therefore others could share in the feeding:

Before the baby came we had talked about a plan of Chris taking care of everything else, and me taking care of the baby. And it’s funny because it hasn’t quite worked
out like that because we’re sharing a lot more responsibility with the baby, which is nice…. I do most of the bottle sanitizing and the bottle stuff. I’m like the chemist with making sure all the bottles have the same amounts and all that. But Chris puts James to bed at night, takes care of bedtime routine. So we’ve kind of worked it out in a way.

Additionally, Chris rented a breast pump from the hospital before he and Desiree went home. Desiree said in her second interview, “I didn’t even know that was going [on],” indicating that Chris took the initiative without waiting for Desiree to tell him what to do. These couples’ interviews suggested that both Brad and Chris took responsibility for parts of the childcare and did not rely on their wives to manage these aspects of care.

Sharing couples also talked about how childcare became a shared enterprise; specifically, they revealed a collaborative decision-making process regarding childcare. Chris talked in his second interview about the feeding decisions he and Desiree made together in the hospital:

By the time we left [the hospital], I think what we had kind of decided was, we’d made a couple decisions, and I think the decisions helped eliminate a lot of the anxiety. [One decision was] that it wasn’t the end of the world if we had to feed [the baby] a bottle.

Chris explained that because “breastfeeding still wasn’t working,” he and Desiree knew they needed to “have a good plan, get [the baby] food, that’s our most important job right now, is just feed him.” By making the feeding plans together, beginning in the hospital and continuing later at home when Chris created a complex pumping spreadsheet for Desiree—
which she said helped “keep [me] motivated” toward the goal of providing breast milk for
the baby for one year—both parents became more involved and invested in the responsibility
for the baby’s care.

Manager-Helpers at Night

Literature on the manager-helper division of labor focuses on household labor and
childcare that occurs during the day. In this section, I demonstrate how manager-helper
dynamics continue into the fourth shift. I focus my analysis on the seven manager-helper
couples in order to extend prior sleep research (Maume, Sebastian, and Bardo 2010) by
uncovering the processes that led to unequal divisions of labor at night. Such processes also
reflect power dynamics within heterosexual couples, particularly the ways that men benefit
from “hidden power” that is embedded in gendered practices and ideologies (Lukes 2004;
Tichenor 2005). Examining couples’ division of labor in the fourth shift allows us to develop
further understandings of hidden power in intimate relationships (see Davis and Greenstein
2013).

Despite the numerous negative health effects resulting from a lack of sleep, sleep is
understudied in sociology. Moreover, whereas we might conceive of the night as “a realm
where activities cease,” Venn et al. (2008: 96) describe it as “another place, both spatial and
temporal, where gender differences are expressed and revealed.” The nighttime division of
childcare labor, especially among parents of newborns who are highly prone to interrupting
their parents’ sleep, is thus a phenomenon ripe for study. According to Venn et al. (2008),
the fourth shift is the continuation of the first three shifts (Hochschild 1989, 1997) into the
night, including emotional activity that is related to children, work, partners, or other family members (e.g., soothing a distraught family member who is unable to sleep due to work or school concerns) and waking up at night to take care of children or domestic chores28 (e.g., feeding or relieving children; completing a load of laundry that needs to be done for the morning).

Scholars have found, based on time diary data, that women sleep slightly more than men (Burgard and Ailshire 2012), but women have lower quality of sleep because their sleep is more likely to be disturbed by family needs than men’s (Burgard 2011; Burgard and Ailshire 2012; Hislop 2007; Maume et al. 2010; Venn 2007; Venn et al. 2008). Sleep is essential for human well-being, and it is certainly the case that getting less sleep will negatively affect one’s health. However, healthy outcomes are also affected by sleep quality, including the amount of time it takes to fall asleep, the amount and kinds of interruptions that occur during the night, sleep disorders, and whether or not a person feels refreshed when they wake up (National Sleep Foundation 2017; U.S. Department of Health and Human Services 2011). Additional evidence that sleep is gendered is suggested by research finding that the worries preventing men and women from falling asleep differed by gender: men are more likely to worry about their work, whereas women are more likely to worry about their family (Maume et al. 2010).

28 While this was unusual among my participants, an example of doing nighttime chores came from Natalie’s second interview: “Usually once I’m up, I’m up. There was one night I came downstairs because [the baby] was up for like three hours; it was a long period of time….I started cleaning because I was up. Chris came down and he said, ‘What are you doing?’ I said, ‘Well, I’m already up.’ He was like, ‘It’s 4:00 in the morning.’ ‘I know, but I might as well do the dishes; I can’t go back to sleep now.’” Thus, Natalie’s primary reason for waking up was to take care of Emma, yet instead of returning to sleep, she stayed up and did housework.
Gendered sleep inequities may be more evident in quality than quantity of sleep (Burgard and Ailshire 2012; Maume et al. 2010). However, gender is not a fixed or static variable, but rather a social construction that individuals can reproduce but also challenge in their daily lives. For example, in one study of dual-earning couples who considered themselves co-parents, mothers and fathers reported having their sleep interrupted evenly (Maume et al. 2010). Overall, however, studies suggest that women are more likely to respond to children’s physical needs at night (Lupton and Barclay 1997; Maume et al. 2010; Venn et al. 2008), whereas fathers are relatively uninvolved in the nighttime care (Rose et al. 2015). When women are the “default parent” during the day, shouldering the majority of childcare responsibilities (Townsend 2002), this continues into the night. Just as mothers are more responsible for continuous childcare during the day and fathers help in more discretionary ways (Coltrane 1996; Craig 2006; Hays 1996; Lamb 1997; LaRossa 1986; Starrels 1994; Sullivan 2004), such practices carry into the night, with fathers opting out of the nighttime care they do not want to do (Rose et al. 2015).

There is also evidence that women subjugate their sleep needs to those of men when it comes to privileging men’s paid labor and sleep over women’s childcare duties (Maume et al. 2010). Research on couples’ care of children has found that mothers and fathers assume that women take responsibility for children (Ferree 1990; Hochschild 1989; Maume et al. 2010; Townsend 2002) and believe that disrupted sleep is a natural part of motherhood (Garey 1999; Hislop and Arber 2003). When gendered roles of childcare are accepted as unchangeable, they go unexamined (Rose et al. 2015). Once mothers are defined as primary nighttime care providers, couples rarely renegotiate these roles, even when mothers return to
paid labor (Maume et al. 2010; Rose et al. 2015; Venn et al. 2008). Taken together, when fathers opt out of and mothers take responsibility for the nighttime care, this reinforces and reproduces gendered differences in childcare responsibilities (Rose et al. 2015).

In this chapter, I extend the idea of the manager-helper dynamic (Coltrane 1989) into the fourth shift and demonstrate the ways women manage the nights and men help, if and when directed. As demonstrated above, couples who divided the childcare as managers and helpers indicated that women were the ones taking responsibly for and making decisions about the child’s care. Men followed women’s cues for what to do and when to do it. I argue that these dynamics carried into the fourth shift, and I analyze the data to demonstrate the processes of the manager-helper dynamic at night. My findings are in line with previous research that finds that women subjugate their own need for sleep in order to protect men’s sleep. Additionally, these practices and justifications remained the same even after women returned to work, further demonstrating how early patterns of labor are embedded in families and are gendered.

My findings address several gaps in the literature of the sociology of sleep and broaden our understanding of how sleep disruptions are gendered, particularly by applying the manager-helper dynamic to the fourth shift, and uncovering the processes that underlie the gendered division of nighttime labor. Specifically, I found that manager-helper couples engaged in practices that affirmed the belief that childcare is women’s responsibility, not men’s, and these practices led to gender-unequal divisions of labor in the fourth shift. As the participants’ narratives reveal, women took responsibility for the nighttime care by planning (e.g., deciding where the baby would sleep), researching feeding and soothing strategies,
waking men up if women needed or wanted help, and encouraging men to sleep through the baby’s night feedings. Men, on the other hand, were passive when it came to the nighttime care, waiting to be told when to help, what to do, and how to do it. Men relied on the research their partners had done and often did not do their own research. Men were rarely resistant to women’s management, or if they were, they wanted more, not less, direction. Participants also naturalized men’s distance from the daily routine of childcare because they were not breastfeeding and had limited time off from paid work. Additionally, since men worked during the day, couples reasoned that men should sleep at night, rather than give care. In this way, couples upheld the belief that men were the only ones “working,” thus devaluing women’s childcare labor.

In line with Venn et al. (2008), I found that couples with children made gendered accommodations around sleep, but I add to their findings with my longitudinal data. In antenatal interviews, women discussed planning to make gendered accommodations around sleep because of their partner’s need to sleep for his work. I found that these gendered accommodations continued at least six months after the child’s birth. Additionally, I contribute to our understandings of gender, work-family responsibilities, and gender inequality (Maume et al. 2010) by analyzing the processes that underlie family interactions and decisions regarding how and whose sleep is protected and privileged. I show that while couples apply a seemingly gender-neutral logic to their division of labor during the fourth shift, their reasoning is consistently gendered.
SLEEP AND (LACK OF) NEGOTIATING THE FOURTH SHIFT DIVISION OF LABOR

One of the many aspects of life that changed for participants after the birth of the baby was their quantity and quality of sleep. Participants shared in their interviews, especially the second interview when babies were between two to seven weeks old, how their lack of sleep affected their moods, work, and relationships with each other. Couples who experienced conflict with one another often attributed their short fuses to a lack of sleep. For example, in the third interview Ed said, “Our memory and patience and tolerance comes and goes with sleep, but I think we both acknowledge that ‘I’m not mad at you, I just haven’t slept in days.’” His partner Jill agreed: “Yeah, I think both of us try to be good about saying, ‘Right now I’m just frustrated with life. It’s not you.’”

Sleep deprivation and its effects are problems for new parents because newborns wake up throughout the night (and day), needing to be fed. Newborns might also cry in the night because of a dirty diaper, uncomfortable gas, or for no reason at all. Even after a baby sleeps longer chunks of time at night, sickness, teething, or myriad factors can contribute to shortened sleep cycles and a baby’s cries in the night. Some participants had babies who slept longer stretches at night at the time of their second interview, such as Andrea and Josh, whose baby slept in five-to-six hour chunks at night. This helped parents feel more rested. Other participants had babies who continued to wake up multiple times throughout the night for months, and, as Ed and Jill’s statement above captures, this often made parents feel frustrated and exhausted.

Sleep is a biological necessity. Sleep deprivation has been used as a form of punishment (Bulkeley 2014; West et al. 1962), and a lack of sleep is perhaps why some
parents of newborns talk about feeling tortured. The National Sleep Foundation (2017) lists a variety of ways that losing sleep affects peoples bodies and minds, including not being able to remember things, having trouble regulating emotions, lowered reaction time, increased risk of developing high blood pressure, increased food cravings that can lead to weight gain, and a compromised immune system. In a baby’s first few weeks—or sometimes for many months—parents experience these effects, yet must continue to care for their child.

While I had not originally included questions about sleep in my interview guides—aside from asking about couples’ plans for nighttime feedings and routines—the topic came up in my first interview, as the answer to my first question. I began the interview with a soon-to-be father by asking, “So what do you anticipate having a baby will be like?” He answered, “Fun, exciting, and full of sleep deprivation for a little while.” This participant continued to bring up sleep throughout his initial interview, mentioning the advice people had given him and his wife about sleep, thinking of ways they might avoid accruing sleep debt, and hoping to trade off the nighttime care so that he and his wife could each get a full night of sleep every other night. In subsequent interviews, I directly asked about sleep and probed for participants’ ideas about the nighttime routine.

The idea of sharing the load of nighttime childcare was repeatedly discussed in my first interviews with parents. Since the women were planning to exclusively breastfeed, I wondered how this would play out after the baby’s birth. While nine of the 12 couples planned to use a breast pump so that men could participate in feeding the baby, two couples mentioned doing so specifically to help share the nighttime feedings. For example, although Pat thought nighttime feedings would mostly fall to his partner, Ashley, he also thought that
he could “kind of rotate in once or twice with the bottle.” Yet after the birth, couples’ plans to share the work of feeding by pumping breast milk rarely materialized; instead, the women who pumped often did so for reasons other than sharing feeding (see Table 6).

**TABLE 6: Pumping Plans and Rationales**

<table>
<thead>
<tr>
<th>Mother’s Name</th>
<th>Pumping Plans T1</th>
<th>Pumping Reasons T2</th>
<th>Pumping Reasons T3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allie</td>
<td>Share</td>
<td>Alleviate BF pain</td>
<td>Alleviate Engorgement</td>
</tr>
<tr>
<td>Andrea</td>
<td>Work</td>
<td>Not Pumping</td>
<td>Work</td>
</tr>
<tr>
<td>Ashley</td>
<td>Work</td>
<td>Increase Supply</td>
<td>Stopped Pumping</td>
</tr>
<tr>
<td>Catherine</td>
<td>Share &amp; Work</td>
<td>Share &amp; Work</td>
<td>Stopped Pumping</td>
</tr>
<tr>
<td>Desiree</td>
<td>Share &amp; Work</td>
<td>Feed (exclusive pumping)</td>
<td>Feed</td>
</tr>
<tr>
<td>Emily</td>
<td>Work</td>
<td>Work</td>
<td>Work</td>
</tr>
<tr>
<td>Holly</td>
<td>Share &amp; Work</td>
<td>Share &amp; Work</td>
<td>Work</td>
</tr>
<tr>
<td>Jill</td>
<td>Share &amp; Work</td>
<td>Share</td>
<td>Work</td>
</tr>
<tr>
<td>Michelle</td>
<td>Share &amp; Work</td>
<td>Establish Supply</td>
<td>Work</td>
</tr>
<tr>
<td>Molly</td>
<td>Share/Flexibility</td>
<td>Establish Supply</td>
<td>Stopped Pumping &amp; Breastfeeding</td>
</tr>
<tr>
<td>Natalie</td>
<td>Share/Flexibility</td>
<td>Alleviate Engorgement</td>
<td>Alleviate Engorgement</td>
</tr>
<tr>
<td>Rachel</td>
<td>Share</td>
<td>Increase Supply</td>
<td>Engorgement</td>
</tr>
</tbody>
</table>
At the time of the second interviews, 11 out of 12 women were pumping for some reason, but only three of them said they were pumping for the purpose of including their partners in the feeding. In these instances, pumping to share feedings did not always result in more rest for women. Holly and Catherine described in their second and third interviews how they tried to pump in order for their partners to feed the baby at night and get more sleep themselves, but missing a feeding led to breast engorgement. For example, Holly said at her second interview that in order to sleep longer:

I’ll pump maybe four or five ounces and then let Michael take one feeding at night and just use that in a bottle and feed William….It doesn’t always work. Sometimes I’m just up anyways because I just get so full that I have to pump when [William] would be doing his normal feeding. I don’t think I really get that much more rest by pumping.

This pumping strategy, which was meant to provide men with a role in nighttime feedings and women with a break from breastfeeding, did not have the intended effect of giving women a break. Women typically woke up regardless, often to pump, and pumping tended to be more work than breastfeeding because it required setting up and then cleaning the equipment. Thus, the initial plan of sharing the night feedings by men feeding with a bottle and women sleeping through a feeding did not work for Holly and Catherine, and only worked temporarily for Jill. By the third interviews, no one was pumping for the purpose of sharing feeding responsibilities with a partner.

The couples I interviewed rarely explicitly negotiated the division of childcare labor in the fourth shift (see also Rose et al. 2015; Venn et al. 2008). At the time of the first
interviews, many had not discussed with their spouse what they thought nighttime feedings would be like. Following the baby’s birth, they continued to lack explicit divisions of labor at night. For example, Allie said at her second interview that she and her husband have “no plan” for how the nights work. Furthermore, Holly described during the third interview a common weekend pattern whereby her husband, Michael, would wake up with the baby early in the morning and Holly would sleep an “extra hour or two.” When I asked them how they came to this arrangement, initially Holly said, “Umm, I don’t know,” and Michael added, “Like, organically.” Couples’ experiences of dividing the labor did not appear to involve literal negotiations; rather, they happened in the moment. Yet these arrangements developed into powerful patterns that held constant for the majority of their child’s first months of life.

To continue Michael and Holly’s story of how they came to their weekend wake-up arrangement, despite Michael’s assertion that it came about “organically,” Holly went on to say:

I guess because I was just so tired, it was like, “Michael you’re up, you’re taking him now. I’m still sleeping,” (laughs). Michael was voluntold (laughs). He was voluntold for the couple hours in the morning on the weekend to let me sleep (laughs). Of course sometimes I wake up at seven when the baby gets up and I’m ready to go, so I’ll let Michael sleep for a few hours and then the next day it will be my turn to sleep in a little bit. So it just kind of depends on how either one of us feels.

Thus, despite their first assertion that their arrangement came about organically, perhaps with little recollection of when it began, upon further examination and reflection, their story
revealed that Holly managed the mornings, telling Michael to either take the baby or letting him sleep and taking the baby herself. Holly’s term for this, “voluntold,” implied a combination of volunteering and telling. While I did not ask her to define this term, it appeared to be the way that Holly characterized her management of the morning childcare. Rather than Michael taking the initiative to volunteer for the morning care, Holly managed the mornings and enlisted his help, as he was the only other adult in the home. Their arrangement was fluid; rather than predetermining who gets up with the baby, as Holly indicated, it “depends” on how they feel.

In the next section, I focus on the seven couples whose division of fourth-shift labor was characterized by women’s management and men’s help. I found that these couples justified their unequally divided labor in two ways: privileging men’s paid labor and using biological explanations. Some couples used both reasons, whereas others used only one. A benefit of longitudinal data is being able to see how couples began making gendered accommodations prior to the baby’s birth. I argue that this established a pattern, which couples continued to follow, using both paid labor and/or biological justifications for men’s lesser involvement.

PRIVILEGING MEN’S SLEEP AND PAID LABOR

The first way manager-helper couples justified men’s lesser involvement with fourth-shift labor was by framing men’s paid labor as more important than women’s unpaid childcare labor, thus privileging men’s need for sleep over women’s. The ideas underpinning this unequal pattern were established prior to the baby’s birth. In our first interviews, I asked
participants how they thought the nighttime feedings would go, and I found that even before the birth of the baby, some couples were making accommodations that privileged men’s sleep based on their paid labor while ignoring the labor involved in childcare. These patterns carried through the second and third interviews, as couples routinely privileged men’s paid labor over women’s childcare labor. Furthermore, as others have found (Maume et al. 2010; Rose et al. 2015; Venn et al. 2008), these arrangements were rarely explicitly negotiated or renegotiated, despite couples’ beliefs that things would change upon women’s return to paid labor. When I asked couples in the first interview how they thought nighttime feedings would work, none of the manager-helper couples mentioned discussing their expectations with their partners. For example, Nick said, “No, we haven’t discussed it one bit.” Ashley thought as far as the “nitty gritty logistics,” she and her partner would just “have to see how it goes.” The only nighttime thing participants had discussed with their partners was their physical sleeping arrangements, which I discuss in detail later.

When I asked about the nighttime routine at subsequent interviews, the answers from manager-helper couples were similar to those given at the first interviews. Michael said at the second interview that he anticipated the night times would “be different when [Holly] goes back to work” but they were “not talking about that too much yet.” Following up with them at the third interview, they said they had not renegotiated the nights, and Holly continued to do the bulk of the fourth-shift labor, despite returning to work after only six weeks of maternity leave. By privileging men’s sleep on the basis that men need to work or “function correctly” at their paid jobs, participants devalued the childcare labor that women accomplished during the day, rendering both their day and night work invisible. But they
also created gender-unequal patterns that, in some instances, continued well past women’s return to paid labor. My findings reveal two main underpinnings of this gendered division of labor during the fourth shift. First, participants emphasized the value of men’s paid labor and men’s need to “function correctly” at work, without acknowledging that it is also work to take care of a baby. Second, participants’ descriptions of their sleeping arrangements implied that they saw mothers as primarily responsible for childcare in the night. For example, couples framed their sleeping arrangements as making it easier on women to take care of the baby in the night, without considering the ways the labor might be shared between them. I discuss both of these framings in turn below.

The Value of Men’s Paid Labor

When I asked in the first interviews how individuals anticipated the nighttime feedings would go, women in manager-helper couples often expected to bear the brunt of the fourth shift in order for men to sleep and therefore be able to function at work. For example, before the baby’s birth, Ashley said of her partner Pat, “I realize he’ll probably be going back to work before I will be, so that’s also not fair to have him get up every time [at night] if he’s waking up in the morning and I’m not.” This excerpt revealed not only Ashley and Pat’s plan for his earlier return to paid employment than hers, which was the case for almost all the couples, but also an assumption that she would not be waking up in the morning, when, in

29 This was not the case for two couples; however, I did not categorize their division of labor as manager-helper. Emily and Brad both received permission from their professors to take two weeks off from classes, thus they returned to their schools at the same time. Jill did not take any formal leave from her work, and instead made informal negotiations with her colleagues to assist with her work. Since her work was mostly done from home, she did not have to leave the home for work, and she started working again before Ed returned to his work.
fact, the baby usually woke her up quite early. Ashley’s underlying message was clear: Pat will be “waking up” to work, whereas staying home to take care of the baby will not involve “work.” Some research finds that women, after the birth of a child, have more flexible time to choose when to go to bed or nap, especially if they are not constrained by paid labor, whereas men are more constrained by their time spent in paid labor (Burgard and Ailshire 2012). However, as the healthy sleep promotion literature indicates, lack of continual sleep leads to unhealthy physical, mental, and emotional outcomes (National Sleep Foundation 2017; U.S. Department of Health and Human Services 2011).

Natalie also described her assumptions about her and Dave’s nighttime division of labor by emphasizing his need to “function correctly” upon returning to work:

I know he’ll have a little bit of paternity leave, which will be good, so I might shake him awake for a little bit. But when he goes back to work, I would really like to let him get as much sleep [as he can]. One of us has to be functioning correctly, and if it’s not me, it’s got to be him (laughs).

In addition to privileging their husbands’ need for sleep, Ashley’s and Natalie’s statements also revealed their plans to manage the fourth shift. Natalie, for example, described planning to “shake [Dave] awake” to help with the baby. Both of their narratives revealed the assumption that they will be the ones in charge, and they will need to prod or ask their husbands to participate in the nighttime care, without considering the possibility of the men waking up on their own to participate.

In the second interviews, when the babies were between two to seven weeks old, I found that the labor of the fourth shift unequally fell to women in manager-helper families.
Ashley and Natalie shouldered the majority of the nighttime care, just as they had anticipated, protecting men’s sleep and privileging their paid labor by doing so. Natalie said, “Since [Dave’s] back to work, I want him to be able to sleep.” Ashley described not wanting to bother Pat with the nighttime childcare labor in order to protect his sleep, undermining her own unpaid labor in comparison to Pat’s paid labor:

There’s been some nights, you know, sometimes I know that he’s got to work and do stuff so I just try to not to bring him in and, you know, just deal with [the baby] being up all night….I need sleep but I am just here and she’s my responsibility right now, or, not that she’s only my responsibility but my res—whatever, right now, I am, this is my job right now.

Ashley’s quote reflects the belief that a woman’s “job” of childrearing is less valuable than men’s paid labor. Ashley acknowledged her own need for sleep, yet framed it as less important because she was “just here” in the home, rather than out working for pay. Ashley demonstrated that she valued Pat’s paid labor more than her own unpaid childcare through her desire for him to get more sleep and her attempts not to bother him in the night. At another point in the interview, when she talked about asking for Pat’s help in the night, she justified this by saying, “But he’s always good with less sleep than I am,” using a biological justification for why Pat should help rather assuming he should share the labor equally. Even though Ashley caught herself, restating “not that she’s only my responsibility,” she clearly revealed that she felt more responsible for the parenting, reinforcing her job as the manager of the fourth shift and Pat as the helper.
In manager-helper couples, men were often complicit in the arrangement, continually deferring to their wife’s management of the fourth shift. At the second interview, Shawn described what typically happened in the night when the baby made noise:

[Catherine] wakes up immediately, and I tend not to. I want to, it just tends not to happen. And then when I do wake up, I figure, well, she’s right there so she’ll turn over and give him a pacifier or whatever, and tend to him. So, I don’t know, it varies. I think generally I get more sleep than she does, and I feel bad about it. It’s been challenging, especially since I have to be at work at 7:00 in the morning, and get home at 5:00. But it’s working. We’re making it work.

Here, Shawn said he both wanted to wake up and felt bad about getting more sleep than Catherine, yet he did not challenge her management. Shawn also used his paid labor as the justification for his greater amount of sleep, reinforcing his privilege. At the end of the above quote Shawn said, “it’s working, we’re making it work.” Yet from his description of the night, there is a lack of “we” participating in the work of “making it work.” Clearly, Catherine was the one “making it work,” allowing Shawn to get more sleep.

The pattern of couples justifying their unequal division of the fourth shift by reasoning that men needed to function at their paid job remained constant at the third interviews, particularly in manager-helper couples where the baby was not sleeping through the night. Women in manager-helper couples continued to do the fourth-shift work and protect men’s sleep. For example, at Catherine and Shawn’s third interview, when their son Jacob was six months old, Catherine described feeling frustrated and sleep deprived as she woke up throughout the night to tend to Jacob. But she prioritized Shawn’s need for sleep
over her own. Importantly, Catherine decided to quit her paid job to stay home with Jacob, making Shawn the sole financial provider for their family. Catherine described the types of frustrations she felt at night:

Yeah, I’ll get mad even though I don’t want [Shawn] to wake up in the middle of the night, because I want him to be alert at work because it’s so important. I still get pissed off because I’m like, [Jacob’s] up again. I’ll like huff and puff just loud enough so Shawn won’t wake, you know? I don’t want him to wake up. Just a little resentfulness that I—a little bitterness that I carry along with me every night.

Catherine acknowledged that the responsibility for caring for Jacob fell to her, despite her exhaustion, and that it was Shawn’s “important work” that superseded her need for sleep. Yet Catherine also resented this arrangement and seemed to be indirectly making her frustration explicit to Shawn through the joint interview. However, Catherine quickly apologized for her resentment, saying, “Yeah, so, that’s bad. What can you do?” indicating that in expressing her frustration she was failing to support her husband or present a unified front. Shawn commented, “We all have our crosses,” passively acknowledging that this was Catherine’s issue to contend with, not his.

Yet there were instances in which couples did not agree on the best ways to care for their child. Catherine discussed how she would sometimes take the baby away from Shawn because she did not like the way he was trying to soothe the baby and wanted him to do it differently. When I asked Shawn how he felt about this, Shawn said he became very frustrated when Jacob would not respond to his “little ritual to get him to sleep,” whereas breastfeeding would often immediately soothe the baby. In Shawn’s estimation, it was not
his soothing that was the problem but rather the fact that Jacob really wanted to breastfeed.

In discussing his frustration at trying to soothe Jacob, Shawn described himself as “getting more and more towards the red zone,” then said, “I wish, I guess as a man…I just wish that there was a way I could just like overpower the situation and just stop it by force.”

Masculinity involves violence (Connell 2005; Schrock and Schwalbe 2009; Schwalbe 2014), and Shawn’s descriptions of “overpower[ing] the situation” and using “force” point to his desire perhaps to use violence to solve the problem of a crying baby. In this instance, Catherine’s reasons for taking the baby were not only to soothe him the way she wanted it done, as the manager of Jacob’s care, but perhaps also out of fear of Shawn’s frustration getting out of control.

Shawn also pointed to his paid job as a justification for why he continued to sleep while Catherine took care of the baby at night:

I want to help out as much as I can, but unfortunately I’ve got to get up at the crack of dawn every morning, so I don’t really have a whole lot of flexibility to be, to get up and stay up. I really hate that it kind of, just the burden, just kind of like shoved off on her to deal with.

Both Catherine and Shawn assumed that Shawn’s paid labor took precedence over Catherine’s unpaid labor when it came to who got to sleep more at night. Catherine felt bitter about being awake at night, and Shawn felt guilty that he was not helping. However, this arrangement was accepted as unchangeable and they did not discuss ways they could renegotiate the situation. Family roles, such as Catherine and Shawn’s, develop out of countless small interactions within families across time (Deutsch 1999). These types of
interactions begin to create more or less equitable situations within families. Rather than being fixed personality traits of the people involved, they are roles that are created and may be contested, but over time can appear natural and immutable.

Catherine and Shawn’s story illuminates some of the processes underlying the ways couples come to have gender-unequal divisions of labor. As they made decisions regarding work and care, their arrangements became further gender-specialized. The decisions they made regarding Jacob’s care revealed Shawn’s overt and hidden power in their relationship. Ultimately, rather than pay for daycare, Catherine quit her job to stay home to care for Jacob, insisting that she did so because she despised her job. Yet she may have also wondered how she would do that job given the heavy burden she carried at home, a burden that continued into the night. The resulting division of paid and care work reinforced Shawn’s overt power as the breadwinner and justified his lesser involvement in Jacob’s care.

In reflecting on their child’s first few months, Catherine and Shawn talked about their intermittent efforts to renegotiate their arrangements. In the first few weeks, Catherine pumped so that Shawn could take one of the night feedings, but that arrangement did not last. They had not initially planned that Catherine would quit her job, but once Catherine made this decision, she stopped pumping, and, since they did not use infant formula, Shawn could not feed Jacob with a bottle. Additionally, with the loss of Catherine’s income, Shawn

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30 When I contacted Catherine via email one month after our second interview to see how things were going, she replied that she was having “difficulty incorporating [Shawn] with nighttime feedings. If I pump and he gives a bottle, I wake up engorged and need to get up and pump anyway. So I am solely doing all the feedings and it’s hard.” Thus their sharing arrangement, which had begun just days prior to our second interview, lasted only a month or less. Catherine’s statement also revealed that she wanted to incorporate Shawn, and it appeared to be her responsibility to figure out a way to do so.
began working on Saturdays for his father’s lawn care business. These arrangements were highly gender-differentiated: Shawn was the provider who worked long hours, six days a week, and when he was home he wished he could take control of getting Jacob to fall asleep, “by force” if necessary. Catherine became the caregiver, staying at home to care for Jacob, exclusively breastfeeding, ultimately relying on what she called “the power of the breast,” and managing the ways Shawn helped with childcare. And while they talked during their second interviews about some limited efforts to renegotiate these arrangements—such as Shawn using the bottle to feed Jacob at night or giving Jacob a bath—by the time of their third interview, Catherine’s narrative revealed that she managed and undertook most of the childcare. In abandoning their renegotiation efforts, Catherine and Shawn further diverged from one another, resulting in gender-stereotypical family arrangements that, to them, appeared natural.

_Sleeping Arrangements and Assumptions about the Lack of Men’s Nighttime Childcare Labor_

Not only did men and women in manager-helper couples make the assumption that men’s work superseded women’s work in terms of their need for sleep, couples also made assumptions about the lack of childcare labor men would do based on their planned and actual sleeping arrangements. For example, couples described how their sleeping arrangements would make it easier for women to tend to the baby at night, implying both women’s responsibility _and_ primacy in the fourth shift. I argue that these behaviors contributed to the unequal roles that women and men took on in nighttime care work.
Whereas, prior to the baby’s birth, couples had often not discussed who would be doing the nighttime childcare, they were more likely to have discussed what their sleeping arrangements would look like with the addition of the baby. They made plans for buying bassinettes or co-sleepers, putting the baby’s bed in their room, switching rooms, or placing the baby’s bed on the woman’s side of the bed. This sometimes meant couples rearranged their furniture or swapped sides of the bed. All twelve of the couples planned to initially sleep in the same room as the baby, but the ways the manager-helper couples talked about these arrangements reinforced the women’s responsibility for childcare: if the men were involved, it would be by “helping” as directed by their partners. Additionally, if men slept through the baby’s nighttime wake-ups, it was because the women “let” them.

The most common reason couples gave for wanting to be in the same room as the baby, at least in the beginning, was the assumption that women could easily tend to the baby when the baby was close by. At the time of the first interviews, couples described ways they had or would set up the baby’s bed. Because Holly and Michael’s bedroom was on a different floor of the house than the baby’s room, Holly was concerned about having to go up and down the stairs in the night. Her description of their sleeping arrangement plans assumed that she would be responsible for the fourth shift without any help from Michael:

We might just move upstairs [into another bedroom] for a while, so I don’t have to go up and down stairs in the middle of the night for feedings. Or, we could just move the crib into our bedroom downstairs. Either way, I kind of think it will be easier for nighttime feedings if the baby is really close by and I don’t have to do much walking or stumbling upstairs half-asleep.
Natalie also planned to have her infant daughter sleep in a bassinette next to the bed so that when the baby wakes up in the night she could “reach for baby, put the baby on [me], and [I] can still just be in bed.” Thus, both Holly and Natalie assumed that the physical closeness of their sleeping arrangement would allow easy and quick access to the baby, and promote more of their own sleep. Yet this assumption, and the arrangements couples put in place as a result of it, situated the mother as the parent primarily responsible for the labor of the fourth shift, and set the stage for a manager-helper dynamic around nighttime care. If the women needed or wanted help, they would have to wake the men up. Furthermore, as Natalie continued to talk, it became clear that she was also concerned with protecting Dave’s sleep. Natalie said that by staying in bed to get the baby there would not be “as much up and down and walking around and not as disturbing to Dad as well if Dad doesn’t wake up for [the feeding].”

Another sleeping arrangement that established women’s greater role in nighttime feedings and prioritized men’s paid labor was for the woman to relocate, such that she slept with the baby, and the father slept alone. As other research has found, people who sleep together are likely to disrupt each other’s sleep, yet the norms of romantic relationships dictate sharing a marital bed (Hislop and Arber 2006; Maume et al. 2010; Venn 2007). In line with this observation, relocating was not common among my participants. Only one couple in my sample, Rachel and Nick, used a relocating strategy to deal with nighttime feedings and care, although it was what they had initially planned to do. Nick recounted in his second interview, when their son Ethan was three weeks old, that after returning from the hospital, he and Rachel shared the labor of the fourth shift, but this arrangement was short-lived:
The first couple of days I was home, we were working [the nights] together, but when it came time [for me] to go to work, I’d have to go to bed and shut the door and turn a fan on. So, I’m getting legitimate sleep and she’s across the hall [with the baby].

The relocation was not an arrangement they had planned, but it was Rachel who established it. Rachel described making the decision to sleep in the baby’s room so that she could immediately respond to his needs without bothering Nick. This arrangement continued until Ethan was two months old. Rachel insisted that the arrangement was “so that Nick can go to work on time,” reinforcing the importance of his sleep and paid labor. Rachel said she did not “want to bother Nick” in the night, but also said:

I don’t want [Nick] to listen to [Ethan] get upset at night, and [Nick] doesn’t understand yet that there are all these little noises that [Ethan] makes that don’t really mean anything, so I’m scared that when we put [Ethan] in his own room, Nick’s going to be up all night long, going back and forth.

Here and elsewhere, Rachel suggested that Nick may have responded worriedly to the baby in the night. In our first interview, she called Nick a “Nervous Nancy” who would need to get acclimated to having a baby. Rachel’s relocating strategy seems to also be a solution to reducing Nick’s presumed anxiety over Ethan’s noises.\(^{31}\) Rachel also reasserted that she was Ethan’s primary caregiver while Nick worked during the day. She explained how this led her to take on greater responsibility for the baby because she knew what his sounds meant and

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\(^{31}\) I neglected to probe with Rachel further to determine if Nick actually responded like this, or if these were Rachel’s assumptions about how he would respond if she was not sleeping in Ethan’s room.
how to respond. Rachel said that part of Nick’s lack of understanding came from the fact that Nick’s “never had a baby before and he’s not watching [Ethan] constantly like I am.”

Even though the most common explanation for the unequal division of labor in the fourth shift was men’s need to perform at work, women’s greater and men’s lesser involvement in the fourth shift persisted even after women returned to paid work. Holly said in her second interview that she was responsible for the labor of the fourth shift “so Michael’s not too tired to go to work.” Anticipating her own return to paid labor, she said, “When we’re both going back to work, it’s going to be more fifty-fifty.” This did not turn out to be the case, however. As other research has found, nighttime childcare arrangements are rarely renegotiated after women return to paid labor (Maume et al 2010; Rose et al. 2015; Venn et al. 2008). At the third interview, Holly described how the baby still slept in the bedroom with her and Michael, and discussed how this may need to change in order to help her get more rest. But as she tried to make it easier on herself to tend to the baby’s needs, her narrative also implied that despite both her and Michael’s full-time work, she would continue to shoulder the majority of the fourth-shift work:

The only reason why I hesitate [to put the baby in his room] is because I know he’s going to need to get up at least one time a night, probably, and still nurse at least once, which means I’m going to have to walk up the stairs (laughs). I don’t really want to do that, so maybe we’ll just put his pack ‘n play in our room for a little while longer [in a place where] he’s not right next to the bed, and maybe I’ll be able to sleep a little better too, since hopefully I won’t hear him rustling as much.
Whereas Michael was not feeding the baby, Holly’s description of the work she anticipated needing to do to get the baby from a different room in order to feed him was something that Michael could do. Yet Michael’s participation in this way was never mentioned by either of them.

Unequal arrangements also persisted among couples who were no longer breastfeeding. In their third interview, Molly and Jason said they continued to sleep in the same room as their son. Molly was no longer breastfeeding and they fed their baby exclusively with formula. While Molly’s body was no longer necessary for the feedings, she continued to be the one handling the nighttime feedings.

We actually sleep in the same room as [the baby] so when I’m up, [Jason’s] pretty much up. I mean, I’m the one feeding him. We literally take the bottle of water and put the formula right next to the bed. So I’ll feed him for the 15 minutes and then put him back to bed. Like, last night it took him about 45 minutes to fall back to sleep, so I was the one with him. But that will switch now in two weeks once I start working again. We’ll be kind of figuring out what works for us.

Molly suggested the arrangement whereby she was largely responsible for nighttime feedings would “switch” once she and Jason were both working. Yet neither Molly nor Jason had explicitly discussed this or made plans for this eventuality, suggesting that Molly might continue to shoulder responsibility for the nighttime feedings even after resuming her paid job.

Overall, I found that manager-helper couples justified men’s lesser involvement in the fourth shift division of labor by framing men’s paid labor as more important than women’s
unpaid labor, which privileged men’s need for sleep over women’s. Women subordinated their own need for sleep in order to protect men’s sleep. Participants went about this in two ways: expressing men’s need to function at work, and making sleeping arrangements that assumed women’s management and men’s lesser involvement in the nighttime care. Prioritizing men’s sleep obscured the work that it takes to care for a baby, and a caregiver’s need to sleep. Not only was women’s labor of childcare rendered invisible and devalued, but also women’s paid labor, since these arrangements did not change once women returned to their paid work. In this way, men received a pass for their lack of involvement in childcare when they also worked for pay, whereas women did not. I turn now to the second way that couples justified their unequal labor of the fourth shift: giving biological accounts.

BIOLOGICAL ACCOUNTS

As couples discussed the division of labor in the fourth shift, I found that they frequently invoked biology to justify their unequal arrangements, specifically: men cannot breastfeed, and heavy (male) sleepers cannot wake up at night. Manager-helper couples used these types of explanations to justify men’s lesser and women’s greater roles in nighttime care. Using biological essentialist ideas about what men and women’s bodies could and could not do also reinforced men’s and women’s roles. Rose et al. (2015) found that couples constructed rationales for their involvement in childcare that drew on gendered notions of motherhood and fatherhood, where mothers were seen to have biological and ideological primacy, and fathers’ involvement was more discretionary. Fathers thus argued that they did not need to be involved in nighttime care. This rationalization also confirms a broader
discourse that children prefer mothers over fathers as nurturers, that mothers have instincts fathers do not, and that women are naturally predisposed to caregiving (Doucet 2009; Rose et al. 2015).

**Men Cannot Breastfeed**

The first biological justification that manager-helper couples used to explain men’s lesser role in nighttime childcare was that the woman’s body was necessary for breastfeeding because by breastfeeding, women provide the baby’s food. Since the majority of the nighttime work involved breastfeeding, men were often excused from the work. For example, Andrea described Josh as “limited” in the ways he could support her “because he can’t physically feed [the baby].” Couples drew on this idea that men’s bodies were unable to breastfeed, and used this as a reason to excuse them from the nighttime labor. This distinction between what men’s and women’s bodies can do is central to the social processes of the reproduction of gender inequality (Connell 2005). Stressing that men’s bodies cannot breastfeed also obscures the other care work that often occurs along with breastfeeding but does not involve the female body. These tasks involved picking the baby up, changing the baby’s diaper, bringing the baby to the mother, getting bottles or pumping supplies ready, burping the baby, and soothing the baby to sleep. Natalie, for example, said after she fed the baby, she would put the baby in the bed with her to prevent the baby from crying “because I know if I put her in the bassinet she’s going to scream, and [Dave’s] up but there’s nothing he can really do because she’s already fed.” Natalie implied that there was no need for Dave to be involved in the nighttime caregiving because he couldn’t feed. Yet, in this scenario, the
baby was already fed and Dave could have soothed her, as Natalie did, to get her to go back to sleep. Thus lumping all of the labor into breastfeeding work naturalizes women’s role in the nighttime feeding and care work. Natalie also described Dave as a heavy sleeper and explained that this too made his involvement in the nighttime care work difficult.

_Heavy Sleepers Will Not Wake Up at Night_

Manager-helper couples often invoked a biological explanation of the man being a “heavy sleeper” in order to explain his lesser involvement in the nighttime care. This explanation was sometimes coupled with the justification that the woman was a “light” sleeper or “finely tuned” to the baby, which justified her greater role in the nighttime care. Some couples explained at multiple interviews that, between the two of them, the man was simply a heavier, deeper, or better sleeper than the woman. For example, in our first interview when I asked Andrea how she thought the nighttime feedings would go, she said she would be doing all the work because “my husband won’t wake up at night; it’s one of those things that I’ve chosen to find entertaining about him, but he can sleep through my alarm and his alarm and lights and everything and he just won’t wake up.” In order to compensate for her husband, Josh’s, inability to wake up at night, Andrea planned to keep the baby’s bassinette by her side of the bed so that at night she would be able to “grab her and feed her and then put her back in.” During Josh’s second interview, he described how Andrea was “really good about taking the nighttime role on herself, without really needing me much,” indicating how Andrea managed the fourth shift and he was the helper, if necessary.
Four other couples described their sleeping situation similarly: because the man was a heavier sleeper, the woman would presumably take responsibility for the fourth shift, and likely do most of the work herself. Moreover, in couples in which the men were described as heavy sleepers, women (and men) discussed the activities women undertook in order to wake men up and get them to help with the nighttime care. The women discussed how they had to further manage the situation, making sure a husband was fully awake and capable of caring for a baby before being able to relax herself. This resulted in women losing even more sleep and doing the mental labor of worrying about the situation (Walzer 1998), even with a husband’s help.

During Holly’s second interview, as well as during the joint third interview with her and Michael, the issue of Michael being a “really heavy sleeper” came up multiple times and was infused with tension. Their son, William, had difficulty sleeping at night during his first few weeks. As Holly put it, “when the sun goes down, he doesn’t want to be put down.” Holly and Michael ended up holding William much of the night for several weeks. Holly described what it took for her to attempt to rest while holding William at night:

I end up sitting up in bed, propped up by…five or six pillows kind of surrounding me, and the little Boppy pillow. I just end up holding him in my arms or laying him on my chest and just kind of head-bobbing myself for a few hours until he’s ready to eat again.

Yet this issue was also compounded by Michael’s heavy sleeping and the work it took Holly to wake him up. Holly spoke at length about this issue during both her second and third
interviews. Her narrative below, from the second interview, describes the efforts she made to disrupt Michael’s sleep so he could help her with the baby:

It has been frustrating sometimes at night because Michael’s a really heavy sleeper, and I’m not, and so even small sounds that the baby makes, I can hear, and it’ll wake me up. But sometimes if I need Michael to just take him for a little while, I have to spend a lot of time making sure Michael is awake. It takes many tries, and I thought he was fully awake one night, and I was like, “Hey, you hold William just for a few minutes, so I can just go to the bathroom, and so I can have a snack.” And it was probably like four in the morning or something. He was like, “Yeah, yeah I can do that,” and he sits up, so I put the baby in his arms, and I come upstairs. I go to the bathroom, and I’m eating a bowl of cereal and I’ve probably been gone maybe two minutes and Michael comes up, like running up the stairs, the baby’s in his arms. He’s like, “How long have I been holding him? I don’t remember you giving me him.” I thought, “Oh my god (laughs), I thought you were totally awake,” so now I make him do math problems before I give him the baby (laughs) in the middle of the night.

Holly was proud of her creative strategy of giving Michael math problems to make sure he was awake, yet this revealed the additional work she had to perform at night to get Michael’s help, despite her own tiredness. Her story also revealed that Michael was not taking the initiative to wake up and be alert. Michael said that night times were “pretty good” for him because of his heavy sleeping and acknowledged that Holly was the one awake with the baby. During the third interview, Holly spoke of the toll sleep deprivation took on her but
also said, “[Michael] is so hard to wake up and so most of the time I think, ehh, if I can’t get him up on the first try, it’s easier just to do it myself.”

In his interviews, Michael struggled between enjoying feeling rested from a full night of sleep while also feeling like he should be doing more work in the night. He said at his second interview:

Holly was making a lot of sacrifices to make [my transition back to work after a week off] smooth. Staying up so I could get more sleep, which I didn’t particularly like. I mean, I did like [it] during the day when I wasn’t dead tired, but I would’ve wished that I could’ve taken some of the, or she would’ve let me take some of the load off of her, and that’s probably still true….She probably lets me sleep too much, but I guess, you know, I’ve got to function at work, but that’s going to be different when she goes back to work.

Despite the burden on Holly, Michael did not take the initiative to do childcare in the night, instead relying on Holly to wake him up when she needed him. The manager-helper dynamic emerges here too, as Michael explained that he wished Holly would have “let” him take some of the burden off her, showing that he followed Holly’s cues for what to do with the baby rather than taking the initiative himself.

Revealing the way the biological explanation of these men as heavy sleepers was gendered, one woman I interviewed, Emily, described herself as a “super deep sleeper,” yet Emily and her partner Brad’s narratives never indicated that this biological predisposition meant that Emily would not or could not wake up with the baby, which challenges the presumption that heavy sleepers—like Josh and Michael—cannot wake up. Moreover,
Emily and Brad talked about Brad being a light sleeper, but neither anticipated that Brad would be the only one to wake up when the baby cried, or need to shake Emily awake to feed the baby (and they did not enact this strategy). Instead, they emphasized that Brad’s light sleeping allowed him to fall back to sleep quickly after waking in the night, thus nighttime waking was less disruptive of his sleep. This couple described their fourth-shift division of labor as more shared—Emily would feed and then Brad would wake up and change the baby’s diaper or pace around the living room to soothe her and help her fall asleep—but the idea that Brad woke up first and would subsequently be responsible for waking Emily to participate in the nighttime care was absent from their narratives. Thus, women’s management of men as heavy sleepers would seem to be as much about gendering the fourth shift as it is about biological inevitabilities.

Catherine also talked about an arrangement they created in which Shawn was supposed to feed the baby one time in the night in order to help her by giving her a break in the night. Shawn proudly told me during the second interview that he had fed the baby three times at night. However, Catherine’s description of what it took for this to happen indicated that she was still managing the situation, both by initiating it through waking Shawn and by making sure Shawn fed Jacob the way she wanted him to. When I asked Catherine if she was able to stay asleep during the feedings Shawn took, she said:

I try. I don’t really stay asleep. Usually I’ll wake [Shawn], tell him to get up ‘cause he’s a deep sleeper, and you know, tell him what to do so he makes sure, so I make sure he burps him efficiently and like, you know, holds him upright for a while ‘cause yeah, like I said, just being anxious about [Jacob] being okay and not choking or
anything like that is hard and, so, but Shawn’s been doing a decent job, so right now, yeah I’ll try to stay asleep for just one feeding.

Despite this being a strategy to help Catherine get more sleep, Catherine’s narrative indicated that she needed to first manage the situation by waking up Shawn, which she attributed to him being “deep sleeper.” Catherine believed she needed to tell Shawn what to do and how to do it, in addition to monitoring the situation to make sure Shawn was doing it correctly. As Shawn had explicitly discussed with me in our first interview, he had neglected to do research on infant feeding and did not anticipate doing so in the future (he said, “I don’t foresee me making the time to do that”), and indicated that he relied on Catherine’s knowledge and caring abilities. If men fail to do this kind of research (and women do it), and thus have a more distant approach to parenting and hence to understanding their children’s rhythms and needs, then women may be legitimately concerned about men’s ability to do a proper job. While it may seem, then, that Catherine has the power at home as she manages Jacob’s care, it seems clear throughout Shawn’s narratives that he does not believe these decisions are worth his time, thereby revealing his ability to treat childcare as optional as Catherine accepts the role of primary caregiver as her duty (Tichenor 2005).

CONCLUSION

Examining the fourth-shift labor reveals subtle inequalities that emerge in the lives of new parents. Although breastfeeding requires the female body, there are many additional components of nighttime care that can be shared by new parents. Participants described physical care such as changing a diaper, burping after the feeding, and soothing to help the
baby fall asleep. Other research has found that couples who are strongly committed to shared parenting believe that breastfeeding can also be shared, despite its being “the most female of activities” (Deutsch 1999: 115). While some couples negotiated ways to share the nighttime labor, just over half of the couples developed a manager-helper dynamic whereby the women managed the fourth shift and the men helped when directed. In these families, the division of labor was unequal, and I found two main ways these couples justified this inequality. First, couples privileged men’s paid work and thus men’s sleep by discussing the importance of men getting enough sleep in order to function at his paid labor, and assumed men’s lesser role in nighttime care through their discussions of their sleeping arrangements. This further devalued women’s labor of childcare, rendering it invisible as men slept through the nighttime care. Second, couples frequently invoked biology to justify their unequal arrangements, which reinforced a gender-unequal division of labor that naturalized men’s lesser and women’s greater roles in nighttime childcare.

Overall, I found that among manager-helper couples, women became the guardians of men’s sleep, taking responsibility for the labor of the fourth shift. Women also protected men’s sleeping, invoking paid labor and individual sleeping characteristics to justify this. This happened across time points, beginning before the birth of the baby and continuing until the child was six months old and most of the women had returned to work. As such, we can see how gender-unequal arrangements set up a pattern in these relationships early on as women continued to dominate the nighttime labor, even after returning to work. This finding corroborates other research (Maume et al. 2010; Rose et al. 2015; Venn et al. 2008), showing that couples do not renegotiate their nighttime labor after women’s return to work.
By privileging and protecting men’s sleep, women participated in the devaluation of their own childcare labor, and furthermore, their paid labor when they went back to it, demonstrating how women continue to manage the second, third, and fourth shifts of labor.

Not only does the devaluation of women’s sleep reinforce gender inequality within families, it also reflects and reinforces inequality more broadly. While participants routinely referred to “going to work” to mean going to one’s paid job in the labor force, it was only men’s paid work that allowed them to “buy out” of the fourth-shift labor. Among manager-helper couples, the fourth-shift labor was rarely renegotiated once women returned to their paid jobs, indicating that the care work and women’s paid work were both devalued.

Devaluing care work and women’s paid work has consequences. One consequence is sleep deprivation, which affects women to a greater extent than men, when women are both managing the fourth shift and protecting men’s sleep. Less sleep, and poor sleep quality, can lead to unhealthy physical, mental, and emotional outcomes, such as irritability, heart disease, slower thinking processes, and increased confusion (National Sleep Foundation 2017; U.S. Department of Health and Human Services 2011). Additionally, this consequence is compounded for single parents who do not have the option of sharing the work of supporting and raising children and for women who work non-traditional shifts in order to be home with their children during the day (Garey 1999; Maume et al. 2010). As this and previous research demonstrates, women suffer more than men from lack of adequate sleep when there are young children in the house.

32 The one notable exception is Allie, who consistently called parenting a “job,” likening it to her paid labor.
Another consequence is the early establishment of unequal patterns of care. When men have or take little time off from their paid labor, they are likely to struggle to participate in the routine care of their children, leading them to rely on their partners as the primary caregiver (Deutsch 1999; Rehel 2014). Paid labor is highly valued—indeed, I do not deny it takes financial income to survive, particularly in the absence of family safety nets—yet my findings indicate that, in manager-helper couples, men’s paid labor was valued more than women’s paid labor. Patterns of caring for children are difficult to change once established (Bobel 2002; Miller 2007; Walzer 1998), and research demonstrates that couples rarely renegotiate their fourth-shift labor (Maume et al. 2010; Rose et al. 2015; Venn et al. 2008).

A final consequence is the overall continued devaluation of taking care of children. We live in a society seemingly focused on prioritizing children: from fetal rights (Bordo 1993) to health outcomes (AAP n.d.; Healthy People 2017) to cultural expectations of intensive mothering (Hays 1996). Yet the work that is required to care for children is not valued. For example, it is unpaid (done by parents, usually mothers) and largely invisible. When done by daycare workers or nannies, it is often underpaid. Care work in general is a low-status occupation, a service sector job that can be outsourced, draining other countries of their mothers (Ehrenreich and Hochschild 2003). My research shows that new mothers take the work of caring for their children very seriously and new fathers may do this too, particularly when they share more of the routine childcare.

Doing more care work is one way that men can affirm the value of this work. I found that participants felt supported when their partner took responsibility for a child’s care, rather than taking for granted that mothers would do the care work. Through couples’ efforts to
share care work, and through structural conditions that allowed them greater flexibility in
determining their work-life balance, couples enacted care and work arrangements that were
more equitable. My data reveal that, particularly when children are young and in need of
constant care, having greater flexibility in home and work arrangements gives families more
opportunities to divide the labor more fairly. Families who desire to make equitable
arrangements would likely benefit from the support of their employers in terms of being
provided with longer time off work and more flexibility in how work arrangements are made,
particularly in a child’s first year.

We all need sleep; however, the presence of small children in the home inevitably
causes sleep disruptions. Although this disruption may only last for a short while, it can also
contribute to the ways that unequal patterns of care, and paid work, are established, thus
sleep is crucial to our understandings of inequality within families and more broadly as we
consider the devaluation of women’s work. While breastfeeding requires female bodies, the
division of the fourth-shift labor need not be inevitable or static. Couples would do well to
explicitly talk about their arrangements and support one another through their willingness to
renegotiate the division of labor if necessary. Couples may also find it supportive to learn
about others’ arrangements, particularly shared arrangements, which could give them new
ideas about how to divide the baby’s care. Finally, by enacting more equitable caring
arrangements at home, hopefully the work of caring will begin to be more valued by
everyone.
CHAPTER 6
CONCLUSION

Ashley: It’s been good to think about [our journey] and interesting and, like I said the last time, I’ll be really interested to see what your findings are and read what you come up with. The experience is just so different for everybody, and obviously, there’s a lot of information, a lot of thoughts and opinions about parenting and breastfeeding.

Pat: Yeah, it’s been a good experience that allows us to be kind of more reflective than we otherwise may have been during the process, about breastfeeding in particular.

- Ashley and Pat, third interview

I began this dissertation by outlining the ways that public health organizations and medical experts frame the lack of breastfeeding—determined through low exclusive breastfeeding rates for at least six months—as a social problem. Because breastfeeding is endorsed as the healthiest, safest, and best way to feed a baby, mothers who want to do “the best” for their baby are expected to breastfeed and abide by the dominant breastfeeding discourse. Mothers, not fathers, are held primarily responsible for their children’s health outcomes and are expected to avoid any negative risks to their children’s health (Hays 1996; Knaak 2010; Lee 2007; Murphy 2000; Stearns 2013; Wolf 2010).

Through my interviews—both before and after the transition to parenthood—with heterosexual couples who planned to breastfeed, I found that, for the most part, they upheld the expert-endorsed breastfeeding discourse. This was particularly apparent among women (and their partners) who experienced few breastfeeding challenges. In contrast, women who faced barriers to breastfeeding not only struggled with their infant feeding choices, but also
grappled with what it meant to be a good mother during the times they were unable to exclusively breastfeed.

Overall, I examined the ways that new parents framed family decisions around doing what’s best for the baby. I found that inequality is reproduced within and between families through couples’ daily actions and decisions. Gender inequality is reproduced within families as couples divided family responsibilities, such as infant care in the night, in unequal ways. Additionally, inequality is reproduced between families as families in socially privileged positions, such as those I interviewed, used their resources to make privatized and individualized family decisions.

In chapter three, I argued that participants felt pressure to conform to and enact the dominant breastfeeding discourse: exclusive breastfeeding and following the “breast is best” dictum. Women, especially, recognized that their identities would be tied to idealized notions of motherhood. Men’s identities did not hinge on caregiving or breastfeeding the ways women’s did. Women’s narratives indicated they felt accountable to others for their feeding decisions, and acknowledged they risked being labeled bad mothers if they did not breastfeed.

Additionally, participants echoed the expert-endorsed dominant breastfeeding discourse as they described their reasons to breastfeed: breastfeeding promotes mother-child bonding, it is healthy, free, and natural. When I probed further about their ideas regarding “natural” breastfeeding, participants distinguished breastfeeding from artificial feeding methods—such as infant formula or using a breast pump—and framed breastfeeding as inherent to the design of women’s bodies. These meanings helped to reinforce the dominant
view that breastfeeding should be natural and easy for women (Braimoh and Davies 2014; Wall 2001). I analyzed women’s “magnified moments” (Hochschild 1994) of barriers they faced to exclusive breastfeeding—such as a pediatrician’s concern over a baby’s lack of growth, or a baby’s refusal to latch or nurse. Through their narratives, mothers talked about the ways they claimed the good mother identity when exclusive breastfeeding was unattainable: pushing through pain, determining and doing the best for baby, and working hard to breastfeed. Rather than challenge the dominant breastfeeding discourse, the ways they performed intensive mothering practices allowed them to align with the dominant breastfeeding discourse and claim the good mother identity. Yet even when they tried their best, women remained accountable for their feeding decisions and practices. This became clear to me as I listened to couples’ narratives in families where women had very few, if any, difficulties breastfeeding. These participants believed that breastfeeding is natural and easy, and even if women encounter some barriers along the way, they should remain committed to breastfeeding and make it work. The dominant breastfeeding discourse can have real consequences for individuals, as women who do not or cannot breastfeed may feel guilty, judged, or stigmatized, or feel as though they have failed as women and as mothers.

In chapter four, I focused on how participants framed bonding with their baby through breastfeeding. Following expert opinions and public health discourses around breastfeeding, many participants hoped to attain this special bond. While some found breast or infant feeding to create a physical and/or emotional attachment to the baby, others did not. In order to protect the bond as well as their identities as parents, some families practiced what I termed family gatekeeping—drawing symbolic barriers around their nuclear family—
in order to purposely and strategically exclude others from the bond. I argued that inequality was reproduced between families as families in socially privileged positions used their resources to make privatized and individualized decisions, such as family gatekeeping. I also found that women, and occasionally men, expressed concern that breastfeeding might exclude fathers from the bond. In their efforts to include men in the bond, women took on a managerial role, even prior to the baby’s birth, by engaging in *daddy worry* and devising *inclusion techniques* to bring men into the bond. These efforts increased women’s invisible, mental labor (Walzer 1998). Moreover, I found that men did not engage in this mental worry work, resulting in a highly gender-unequal division of mental labor between women and men. This chapter thus provides insight into the contradictions that heterosexual, middle-class couples may encounter as they try to enact the ideal of the “new father” (Goldscheider and Waite 1991; Kushner et al. 2017; Wall and Arnold 2007; Yeung et al. 2001)—whereby men are nurturing, involved in childcare, and engage in more egalitarian family practices—along with the ideal of breastfeeding. My research suggests that it is largely women who undertake efforts to resolve these contradictions, yet these efforts are largely invisible and unacknowledged.

In chapter five, I argued that the division of emotional and practical labor that takes place at night, what scholars term the fourth shift (Venn et al. 2008), is unequal and consequential. I found that seven of the couples I interviewed developed a manager-helper dynamic in which women managed the fourth shift and men helped when directed. In these couples, women took responsibility for childcare, did research when necessary, figured out ways to meet their infants’ needs at night with little assistance from their partners, and
encouraged their partners to sleep through the night. Men, on the other hand, as helpers, took on a more passive, peripheral role whereby they did not take responsibility or initiative for the child’s care. They were often complicit in the arrangements directed by women, and while some of them were willing to help out when necessary, they followed women’s cues to do so.

I found that, despite the seemingly (gender neutral) logical reasoning behind their unequal division of labor in the fourth shift—privileging men’s sleep because he needed to function correctly at work, and invoking biology to justify women’s greater and men’s lesser involvement in the care—these reasons were consistently gendered. For example, although men’s sleep was privileged over women’s due to their need to function correctly at work, when women returned to their paid labor, couples rarely renegotiated the division of labor, revealing that women’s paid labor was not valued in the same way as men’s. Moreover, while only one woman participant identified herself as a heavy sleeper, she expressed no concerns about her ability to wake up at night to feed and described no difficulties in this regard, whereas couples often referred to men’s heavy sleeping to explain why men would not wake up at night.

My research contributes to the literature by revealing that couples, even prior to the birth of a child, make plans about who will get sleep, when, and how, and that these often highly gendered plans continue over time, even after women return to their paid jobs. I argued that these practices reinforced a gender-unequal division of labor that naturalized men’s lesser and women’s greater roles in nighttime care, thereby reproducing inequality within families and more broadly as women’s paid and unpaid labor were devalued.
It is important to address how my sample demographics—married heterosexual couples who were white and middle- or upper-middle class—may have shaped my results. I will discuss several points here. First, there are demographic differences when we consider who is more likely to breastfeed, as I mentioned in chapter three. Women who are more likely to breastfeed are white, married, middle- and upper-class, highly educated, older, and have highly educated partners (Gibson-Davis and Brooks-Gunn 2007; Guzzo and Lee 2008; Lee et al. 2009; Ryan, Wenjun, and Acosta 2002). Importantly here is the point of women being married: married women are also more likely to have a higher socioeconomic status than nonmarried women. Researchers speculate that the higher socioeconomic status of married women may explain the relationship between family structure and parenting practices, such as the higher likelihood that married women will breastfeed (Brown 2000; Carlson and Corcoran 2001; Guzzo and Lee 2008). Thus, had I interviewed non-married women or low-income women, it is likely that my results would have been different in how they went about making their decisions regarding their infant feeding strategies.

Additionally, low-income women have less access to resources—such as hiring a private lactation consultant, which several of my participants attributed to their continued breastfeeding ability—thus for low-income women who desire to breastfeed, they have fewer instrumental supports in their efforts to do so. Research has found that low-income mothers sound like middle-class mothers in many ways when they talk about parenting—such as putting their children’s needs ahead of their own and wanting to provide the best for their children—but their logic behind their parenting strategies is informed by their working class or poor contexts (Elliott et al. 2013; Verduzco-Baker 2017). Low-income mothers are
constrained by their structural conditions: low-wage jobs that provide little or no time off for the birth of a baby, and no flexibility to pump. Despite the provision under the Affordable Care Act for women to have time to pump at work, research suggests that women may not be aware of these provisions, or may be too worried about losing their jobs to request them (Hoffman 2017). Additionally, single mothers are more likely than married mothers to be poor, meaning that lower-income women are less likely than higher income women to have a partner in the home who could provide them with practical and emotional support (Verduzco-Baker 2017).

The dissertation makes three theoretical contributions to our understanding of families and gender inequality. First, it is imperative to continue to study families’ negotiations of routine aspects of life—such as childcare, housework, emotion work—in order to understand the processes that lead to unequal divisions of labor. Routine interactions and choices—while often seemingly minor, such as who wakes up at night to tend to a baby’s cries or who should research feeding strategies and parenting—within families lead to patterns of care that may or may not be equitable. Patterns are established early on and are difficult to change because they appear natural and fixed. My data, deriving from interviews with parents over time—before the birth of their baby, shortly after the birth, when the baby was six months old—provide insights into how these negotiations of family life played out over time. Qualitative and quantitative research on families should continue to use longitudinal research methods to document changes in practical and emotional family care.
Second, my research contributes to the literature on the manager-helper roles that other studies have found in married heterosexual couples. Couples I interviewed who engaged in more sharing of childcare demonstrated that assuming a manager-helper dynamic is not inevitable, even while breastfeeding. Moreover, while some scholars argue that mothers engage in maternal gatekeeping by resisting men’s involvement in childcare and seeking to control and manage the domestic realm, which inhibits men’s and women’s collaboration in family work (Allen and Hawkins 1999), I posit that women and men collaborated in constructing manager-helper roles. Men sometimes resisted women’s management, but their narratives suggest this resistance was short lived and, in some instances, created an even greater divide between managing and helping, as men resisted taking responsibility for making family care decisions. Women’s and men’s adoption of childcare practices in which women took on responsibilities and men did not, led to the emergence of inequality.

Third, the research demonstrates how men consistently benefit from gendered beliefs and the ways these beliefs are put into practice within families. Manager-helper couples’ narratives reveal how men defer to women’s management, which provides women with power within the childcare realm. Yet because care work is devalued, this power is limited. In order to work toward gender equality within families and more broadly, we need to value care work, because every person is, at some point, the recipient of someone else’s care. Society would likely benefit by recognizing the work of caring. As I discuss further below, we would do well to create public policies that would provide families with greater supports.
The dissertation additionally holds two practical implications for family life. First, while family life remains relegated to the private realm, families often struggle due to the lack of structural and social supports available in the U.S., especially compared to other western countries. Despite rhetoric about the value of family, public policies designed to support parents, in terms of birth-related benefits, child benefits, and public spending on children, are lacking. Paid leave is employer-dependent in the United States. Recently, some technology companies have increased their parental benefits; Microsoft, for example, now offers up to 20 weeks of paid leave for mothers, and up to 12 weeks paid leave for non-birth partners (Kelly 2015). While these types of benefits are an improvement, they are offered by very few companies.

Other western countries provide much more social support to new parents through government-provided maternity benefits (e.g., employment-protected leave of absence from work), flexible paid parental leave options (e.g., higher payments for shorter leave or lower payments for longer leave), paid paternity leave, and cash benefits (“birth grants”) or baby necessities (e.g., clothing and diapers) following a child’s birth (OECD 2016). For example, the United Kingdom allows mothers to claim up to nine months and Canada allows around 20 weeks of maternity benefits. Paternity benefits, in terms of paid leave from work, are generally much shorter, an average of one to two weeks for countries that do offer paternity leave, such as the United Kingdom, France, and Sweden (OECD 2016). Countries such as Iceland and Norway provide benefits to mothers regardless of their employment status, whereas countries such as Belgium and Ireland provide new mothers with “birth grants” (OECD 2016).
The U.S. offers *none* of the aforementioned benefits. And while the U.S. does offer a child tax allowance, the U.S. spends very little on family benefits and education for children under the age of five, such as subsidized childcare, compared to countries such as Finland, France, and New Zealand (OECD 2016). Thus, in terms of social policies that could support families raising children, the U.S. appears to be relatively family- *unfriendly*. These are areas for improvement that would help all families have wider safety nets, rather than relying on individual employers, existing family support, or private resources. Without policies that support families, we will continue to see growing inequality between families in different social classes, particularly with the disappearance of the middle class and stable jobs that pay a living wage. The costs of raising a family are high, and the financial and social supports are low.

The second implication my dissertation holds regarding family life concerns practical ways to support new parents. Participants often said they felt judged by others, not only for their infant feeding choices, but regarding parenting in general. In the third interview, Chris said he appreciated being able to share his thoughts on parenting for this study because “people at work will ask how things are going, and it’s almost like you’re afraid to say anything bad because then it makes it seem like you’re just complaining, or a bad parent.” While fathers were less likely than mothers to fear judged by their parenting, Chris’ statement indicates that some men may feel this way too.

Additionally, many parents—such as Ashley and Pat, quoted at the beginning of this chapter—expressed how nice it was to talk with someone about their anticipations and experiences without constant input or unsolicited advice. Parents reported being tired of
hearing others’ stories and advice, sometimes cringing at others’ horror stories when they wanted to focus on positive things, and other times dreading positive stories when they were struggling. For example, Rachel called the experience of being interviewed delightful and likened it to a counseling session, because it was all about her: “For me, I think there’s something that’s sort of narcissistic about contributing to your research. Just sitting here talking about yourself for two hours—it’s delightful. It’s like seeing a psychiatrist or something. I mean, it’s been great. We’ve liked it.” A couple of participants described enjoying the first interviews because they said they had not talked about some of the issues I brought up. As Nick said, “It really jump-started our discussion about everything, the whole breastfeeding thing.” A couple of participants also mentioned that they felt support from me, such as Molly who said:

I really enjoyed [participating] because I felt like you were our support system because, like I said, I didn’t talk to a lot of people about [breastfeeding] so when we did the [first interview] and you were asking questions, like, I never thought of that. I never thought of who would be getting up in the middle of the night.

Thus while I did not give advice and I refrained from talking much about myself, I was surprised that participants found my presence and my questions to be supportive.

Men, in particular, articulated appreciation for the opportunities to share their thoughts on their experiences, indicating how rare it was for them to have the opportunity to talk about these topics. While men often reported being unable to speak for their partners in terms of breastfeeding, they had much to say about their expectations, beliefs, feelings,
experiences, and parenting overall. And they insinuated that no one was asking them about these topics. For example, Graham said he enjoyed the interviews because:

I’m getting to talk about something for a little while that nobody else is asking. The only time I get asked things usually is at work, and it’s more stupid questions, where they could have searched themselves and found the answer. Whereas you’re asking me actually what our experience was like. Only we have that answer. I don’t mind sharing it.

Graham thus revealed his desire to talk about his experiences in the transition to parenthood, but said that for him there was not a social space where he could do so. Elsewhere, I argue that men rely on their female partners to play a supportive role because men do not have access to the support networks that women have (Fitzwater Gonzales and Elliott n.d.). Men’s answers regarding their participation in this study revealed that men would likely benefit from having more people to talk to, and to listen to them talk.

Overall, parents expressed the individual challenges they dealt with and the choices they made regarding their feeding strategies, parenting practices, and navigating the changes that having a baby brought into their lives. Of course, these challenges are not unique to them and reflect broader patterns of care work and paid labor in the U.S. Many of their practices revealed gender-unequal arrangements within their families, as well as a heavy reliance on private resources, reflecting the persistence of gender inequality and the lack of publicly available resources in the U.S. Recognizing and supporting the work of caring for family members, while disentangling this work from gendered beliefs, would help reduce
gender inequality within heterosexual households as well as inequality more generally between families.


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Appendix A

Interview Guides
Although my goal was to have unstructured, open-ended interviews, in order to obtain IRB approval, they asked that I describe my interview questions in detail. Therefore, in the interviews, I tried to stick to the main ideas, and used the sub-questions as prompts.

T1 Interview Guide
Questions for mother
• Why did you decide to breastfeed? When did you decide that you would breastfeed?
  o Were there people in your life who influenced this decision?
  o Were there things you read in books or online that influenced this decision?
  o Have you spoken with a doctor or healthcare provider about breastfeeding?
• What does breastfeeding mean to you?
  o Where do those ideas come from? Are they connected to (above question)?
• What are you expectations about breastfeeding?
  o Are there people in your life (family/friends) who have shared their experiences?
  o What do you think breastfeeding will mean for you and the baby (or, your relationship with the baby?)
  o Are your feelings negative or positive or neutral?
  o How do you feel talking with me, or others, about breastfeeding? Is it a comfortable topic for you? Is it uncomfortable?
  o What are you anticipations about breastfeeding in public, or around other people?
  o In an ideal situation, everything will work out for breastfeeding, but in case that it doesn’t, what do you think you might do?
    ▪ Who might you talk to about breastfeeding problems? (Doctor, lactation specialist, family, friends?)
    ▪ What kinds of alternatives would you use to your own breast milk for feeding your infant?
  o What do you think breastfeeding will mean for you and your partner’s relationship? What kinds of ways do you think your partner might be involved when it comes to feeding the baby?
  o How do you anticipate nighttime feedings will work?
  o What do you think breastfeeding will mean for your partner’s relationship with the baby?
  o **If** she brings up pumping (breast milk):
    ▪ What’s your plan for pumping? How do you think that might work?
    ▪ Do you have any anticipations about pumping?
• How long do you plan to breastfeed, in an ideal situation? What’s your idea of your breastfeeding timeline?
• What’s your plan for working after the baby is born?
What will this mean for feeding your baby?

How do you feel about letting other people feed the baby?
  - Your partner, other family members, people at a daycare, etc.?

Is there anything else you wanted to share about breastfeeding, or anything else you’ve thought of that you think I should know?

I would like to keep in touch with you throughout the study, just checking in with you about every month until the end of the study, is that ok?

What is the best way to contact you? Phone, text, email, other?

What meal can I bring you next time?

Is there anyone LOCAL you might refer me to? (maybe ask if I can send blurb to pass on)

Questions for partner

Tell me about times you and your partner have talked about breastfeeding. How did you decide to breastfeed? When did you make this decision?
  - Were there people in your life who influenced this decision?
  - Were there things you read in books or online that influenced this decision?
  - Have you spoken with a doctor or healthcare provider about breastfeeding?

What does breastfeeding mean to you?
  - Where do those ideas come from? Are they connected to (above question)?

What are your expectations about breastfeeding?
  - Are there people in your life (family/friends) who have shared their experiences?
  - What do you think breastfeeding will mean for your relationship with the baby?
  - How do you feel talking with me, or others, about breastfeeding? Is it a comfortable topic for you? Is it uncomfortable?
  - In an ideal situation, everything will work out for breastfeeding, but in case that it doesn’t, what do you think you might do?
    - Who might you talk to about breastfeeding problems? (Doctor, lactation specialist, family, friends?)
    - What do you think you all would do if your partner was unable to breastfeed the baby, as far as what to feed the baby?

What do you think breastfeeding will mean for you and your partner’s relationship?
  - What kinds of ways do you think you might be involved when it comes to feeding the baby?
  - How do you anticipate nighttime feedings will work?
  - What do you think breastfeeding will mean for your partner’s relationship with the baby?
  - **IF** partner brings up pumping (breast milk):
    - What’s the plan for pumping? How do you think that might work?
    - Do you have any anticipations about pumping?

What’s your plan for working after the baby is born?

Is there anything else you wanted to share about breastfeeding, or anything else you’ve thought of that you think I should know?
• I would like to keep in touch with you throughout the study, just checking in with you about every month until the end of the study, is that ok?
• What is the best way to contact you? Phone, text, email, other?
• What meal can I bring you next time?
T1 Demographic Questionnaire for R to complete at end of interview

Please complete the following about your demographical information. If you prefer, we can do this part verbally. Please let me know if you have any questions or need clarification on anything.

What is your age? ______________

What is your relationship status with your partner? ______________________________

How long have you been with your partner (total time together)? ______________

If you are married, how long have you been married? _________________________

What is your race and/or ethnicity? ______________________________________

What is the highest level of education you’ve received? __________________________

What is your employment status? ______________________________

What is your occupation? _________________________________________

What is your household income? ______________________________________

What is your mother’s highest level of education? _____________________________

What is/was your mother’s occupation? ______________________________________

What is your father’s highest level of education? ______________________________

What is/was your father’s occupation? ______________________________________
Questions for mother

- How is it going? (What’s the bigger picture?)
  - How was the birth? Do you want to tell me about the birth? That is up to you to share if you want to or not.
  - How was the initial breastfeeding experience?
    - Where did you give birth? (hospital, birthing center, home, water, etc.)
    - What happened as soon as the baby was born? (take baby away, put baby on mom’s chest, etc.)
    - Was the hospital/birthing center respectful of your wishes? (In terms of, did they insist you breastfeed? Did they try to give baby a bottle or pacifier?)
  - What was the breastfeeding support like in hospital/birthing center?
- How was breastfeeding when you came home from the hospital/birthing center?
  - What kind of support have you received? (Medical professional, family, friend, partner, etc.)
- Tell me what feeding your baby looks like. What do you do? What does your partner do? Is there a routine?
  - How are the nighttime feedings?
    - Do you and your partner go to bed at the same time? Is that important? Why/not?
    - What about waking up in the morning?
  - How are the daytime feedings?
  - How about housework?
  - Are you pumping? Are you planning to pump? Now that you’ve had experiences with breastfeeding, what do you think about pumping?
- How’s your relationship with your baby, in connection with feeding?
- How’s it going between you and your partner?
  - What does your partner do when it comes to feeding your baby? (May have already answered this above.)
- How’s your relationship?
  - How’s your partner’s relationship with the baby? What makes you feel connected with the baby?
- What’s been most surprising to you about breastfeeding?
  - In what ways did you feel prepared?
  - In what ways did you feel unprepared?
  - What’s been easy?
  - What’s been challenging?
  - Did all your “preparation” (readings, talking to others, mental prep) come in handy? Looking back, what do you think about all the preparation you did?
- Last time, we talked about your plan for going back to work. Has anything changed?
- What about your timeline for breastfeeding, has that changed? How do you feel about that now?
• Is there anything else you wanted to share about breastfeeding, or anything else you’ve thought of that you think I should know?
• General: Have any of the “basic demographics” answers changed?

Questions for partner
• How is it going? (What’s the bigger picture?)
  o How was the birth? Do you want to tell me about the birth? That is up to you to share if you want to or not.
  o How was the initial breastfeeding experience?
    ▪ Where did you give birth? (hospital, birthing center, home, water, etc.)
    ▪ What happened as soon as the baby was born? (take baby away, put baby on mom’s chest, etc.)
    ▪ Was the hospital/birthing center respectful of your wishes? (In terms of, did they insist you breastfeed? Did they try to give baby a bottle or pacifier?)
    ▪ What was the breastfeeding support like in hospital/birthing center?
  o How was breastfeeding when you came home from the hospital/birthing center?
    ▪ What kind of support has your family received? (Medical professional, family, friends, etc.)
  o Tell me what feeding your baby looks like. What do you do? What does your partner do? Is there a routine?
    ▪ How are the nighttime feedings?
      • Do you and your partner go to bed at the same time? Is that important? Why/not?
      • What about waking up in the morning?
    ▪ How are the daytime feedings?
    ▪ How about housework?
    ▪ Is your partner pumping? If so, how is that going?
  o How’s your relationship with your baby? What makes you feel connected with the baby?
• How’s it going between you and your partner?
  o What does your partner do when it comes to feeding your baby? (May have already answered this above.)
  o How’s your relationship?
  o How’s your partner’s relationship with the baby?
• What’s been most surprising to you about feeding your baby?
  o In what ways did you feel prepared?
  o In what ways did you feel unprepared?
  o What’s been easy?
  o What’s been challenging?
  o Did all your “preparation” (readings, talking to others, mental prep) come in handy? Looking back, what do you think about all the preparation you did?
• Last time, we talked about your plan for going back to work. Has anything changed?
• Is there anything else you wanted to share about breastfeeding, or anything else you’ve thought of that you think I should know?
• **General:** Have any of the “basic demographics” answers changed?
T3 Interview Guide
Caveat: The information you’ve told me in previous interviews is confidential between you and me, and what you choose to share with your spouse is up to you. Some of the questions for this interview may be worded in such a way that you feel like I’m following up with a previous issue we talked about, but I just want to reassure you that these are questions I’m asking everyone, and I’m assuming that people have different experiences.

Questions for couple

• Tell me about what feeding your baby looks like. Is there a routine?
  o What does mom do? What does dad/partner do?
  o How do you feel about this? About these actions?
  o Are you breastfeeding? If yes or no, how do you feel about this?
  o Are you feeding your baby anything else? Solid food? Supplementing with formula? Other breast milk?

• Tell me about the last few months since we’ve talked. What’s changed?
  o How has reality compared with your anticipations about feeding your baby, if you can remember them?
  o How did your preparations (reading, classes, talking to people) for feeding your baby help you or not?
  o Let’s talk about breastfeeding in public. What kinds of opportunities have you had? How do you (both) feel about it? How have others reacted?

• If breastfeeding has ended…
  o Let’s talk about when you stopped breastfeeding. Can you tell me what went into that decision?
  o How did you feel about that?

• Can you tell me if you’ve heard of human milk banks?
  o What knowledge do you have about human milk banks or human milk sharing?
  o Did you ever consider using milk from milk banks? Why/not?
  o Did you ever consider donating extra pumped milk to a milk bank?
  o What about regulated vs. non-regulated milk banks?
  o Did you ever consider sharing milk with someone you know?

• Let’s talk about your (the couple’s) relationship. How are things going?
  o How’s your sex life?
  o How’s your communication?
  o How is your conflict? Sometimes kids can cause stress…
  o Has having a baby changed things around here? How so?
  o How does mom feel about her body? About “baby weight”? Have you done anything different (diet, exercise) because of that?
  o Tell me about the things that have to get done around the house, regardless of whether or not you have a baby. Who does what around the house?

• Tell me about your relationships with the baby.
  o Do you feel like your relationship with the baby is connected to feeding? How so?
Let’s talk about work (This is mainly for mom as most of the partners I talked to already had returned to work by the time we did the T2 interview).
  o Did you go back to work?
  o If so, when?
  o If not, why not?
When I interviewed families at the first time point, many people said that the important things about BF were that it’s NATURAL, it’s HEALTHY, and it’s FREE. Now that you’ve experienced BF, what do you think about those things?
I’d like to talk about the concept of “isolation.” Think back over the last six months and your experiences of becoming new parents.
  o Were there times that one or both of you felt isolated? What was going on?
  o How did you feel like you supported each other?
  o How did you feel like others supported you as a family? As individuals?
  o What are ways that you might have felt less isolated?
  o What are ways that you might have felt more supported?
  o If you did feel isolated, did you ever reach out to people around you (physically near to your location)? (Family, friends, groups via Facebook, groups via church…?)
Let’s talk about the future.
  o What are your anticipations for the future, in terms of feeding your baby?
  o If you’re breastfeeding, what’s your plan now, knowing what you now know?
  o If you could do this all again, would anything change? How so?
  o I know it’s early, but do you think you’ll have other children? How might your anticipations be different for another baby?
Why did you choose to take part in this study? How has it been?
What has changed in terms of your demographics?
  o Mainly: relationship status, education, employment status, occupation, household income.