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A Collective Metamorphosis of Breastfeeding Mothers: A Phenomenological Exploration of a Face-to-Face Healthcare Provider Facilitated Peer Support Group

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To the Graduate Council:

I am submitting herewith a dissertation written by Emily Alexandria Tucker entitled "A Collective Metamorphosis of Breastfeeding Mothers: A Phenomenological Exploration of a Face-to-Face Healthcare Provider Facilitated Peer Support Group." I have examined the final electronic copy of this dissertation for form and content and recommend that it be accepted in partial fulfillment of the requirements for the degree of Doctor of Philosophy, with a major in Child and Family Studies.

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A Collective Metamorphosis of Breastfeeding Mothers: A Phenomenological Exploration of a Face-to-Face Healthcare Provider Facilitated Peer Support Group

A Dissertation Presented for the

Doctor of Philosophy

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Dedication

For my precious husband who constantly pushes me beyond my realm of possibility. This dissertation would not have been possible without your relentless support. You are everything I am not and for that I will forever be grateful. To my daughter, because of you I know my own strength. You are everything I never knew I needed; I love you.

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Abstract

This research study used phenomenology to examine a face-to-face healthcare facilitated breastfeeding support group. Participant observations and phenomenology were used to address the following research questions: 1) what are the lived experiences of the women participating a breastfeeding support group, 2) how does the group influence their lived experiences, and 3) what were the common experiences of these women? The support group participants were observed while the researcher acted as a participant observer over the course of an eleven-month period. There were a total of seven women interviewed about their lived experiences breastfeeding and attending the support group. Data from the participant observations and interviews were analyzed at the same time using recursive qualitative methods. A codebook was generated to direct the analysis of the observation data. The interviews were analyzed according to the guidelines outlined by the Phenomenology Research Group at the University of Tennessee, Knoxville. Once analysis was completed, the findings revealed a common thread of transformation in the breastfeeding relationship for these mothers, creating a story of collective metamorphosis. Specifically, mothers found themselves living in a state of uncertainty that they knew they couldn't remain in, as a result, they sought the support of the group and found a safe space where they were able to make small changes over time. In the end, mothers emerged from the group with a new sense of confidence in their abilities to successfully address their breastfeeding struggles. As such, a story of collective metamorphosis is discussed and presented. The findings from this study further ideas found in current literature and also identified some important inconsistencies that need to be further investigated.

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Chapter 1: Introduction

Breast milk is uniquely suited to satisfy infant nutritional needs. In fact, the nutritional composition of breastmilk not only changes throughout a single feeding to meet the individual needs of the infant, but also changes as the infant ages (Picciano, 2001). Additionally, there are significant health benefits associated with breastfeeding for both the mother and the infant (Bernier et al., 2000; Chung et al., 2007; Collaborative Group on Hormonal Factors in Breast Cancer (CGHFBC), 2002; Dermer, 2001; Eidelman et al., 2012). Due to the benefits associated with breastfeeding, both the World Health Organization (WHO) and the American Academy of Pediatrics (AAP) recommends exclusive breastfeeding for about six months (Eidelman, 2012; WHO, 2018). Though breastfeeding is considered the ideal source of nutrition for infants, in the United States (US) most infants are not being breastfed for the recommended duration (Centers for Disease Control and Prevention (CDC), 2020). The 2020 Breastfeeding Report Card revealed that 25.6% of infants born in 2017 were exclusively breastfed through six months of age (CDC, 2020). There are several factors that influence breastfeeding rates in the US including, but not limited to, adequate family support, peer support, social context, perceived support from husbands/partners and maternal work circumstances (Arora et al., 2000; Brodribb, Fallon, Hegney & O'Brien, 2007; Dennis, Hodnett, Gallop & Chalmers, 2002; Foster, Slade, & Wilson, 1996; Guttman & Zimmerman 2000; Hawkins, Griffiths, Law & Millennium Cohort Study, 2007; Johnston & Esposito, 2007; Kimbro, 2006; Kong & Lee, 2004; Rempel, 2004). Thus, understanding breastfeeding rates and breastfeeding experiences is complex and multifaceted.

The purpose of this dissertation is to investigate a US healthcare provider facilitated face-to-face breastfeeding support group associated with a local hospital in a medium sized city in the State of Tennessee where breastfeeding rates are lower than the national averages (CDC, 2018).

This study involved ethnographic observations of the group and phenomenological interviews of seven women attending the group. Observations were used to gain entry into the group culture, build relationships with cultural informants, and recruit participants for the interview portion of the study. Due to COVID-19, observations were only conducted at the beginning of the research project. The implications of COVID-19 on the research design and findings will be discussed in more depth. Overall, however, interviews served as the primary data source and were used in conjunction with the initial ethnographic observations to provide a comprehensive picture of the structure, values, and practices of the group as well as a thorough description of the experiences of the women attending the group. More specifically, this study described the common meanings of lived experiences for 7 mothers participating in the same breastfeeding support group.

Breastfeeding is both a physical action as well as a personal experience that can lead to the need for both medical and emotional support for mothers (Torres, 2014). Thus, it is important to consider the types of medical and emotional support women seek. Currently, the literature on breastfeeding support groups addresses peer groups (Arora et al., 2000; Brodribb et al., 2007; Burns & Schmied, 2017; Dennis et al., 2002; Foster et al., 1996; Kong & Lee, 2004; for review see McInnes & Chambers 2008; Rempel, 2004; Schmied et al. 2011), social media groups with their primary interactions occurring over the internet (Bridges, Howell & Schmied, 2018; Cavalcanti, Cabral, Toledo & Osório, 2019; Lebron, St. George, Echembrecher & Alvarez, 2020; Regan & Brown, 2019), and support from medical professionals (Bunik et al., 2010; Burns, Fenwick, Sheehan & Schmied, 2016; for review see McInnes & Chambers, 2008; Schmied et al. 2011). Furthermore, studies that have investigated both peer and professional support in one study have done so comparing the differences (Burns & Schmied, 2017; Burns et al., 2012; for review see McInnes & Chambers 2008; Schmied et al. 2011) and have not examined a group that

provides both in one setting. Thus, this previously established group available to breastfeeding mothers provided women the unique opportunity to seek medical and peer support in one location and provides a thorough description currently lacking in the breastfeeding literature.

In addition to the rare qualities of the group structure, the qualitative methods utilized in this study provided the ability to obtain a detailed description of the group as well as the experiences of the women participating in the group. A metasynthesis of qualitative breastfeeding studies revealed that mothers expressed the importance of maternal commitment, adaptation, and support from multiple sources as important aspects to maintaining both the personal and physical demands of breastfeeding (Nelson, 2006). Currently, the majority of breastfeeding support group research focuses on the effectiveness of breastfeeding support groups and largely neglects the organization and contextual aspects of support groups (Leeming, Marshall and Locke, 2017). Thus, it is important to not only generate rich description of the lived experiences of breastfeeding mothers, but also it is necessary to develop a clear picture of the physical and contextual characteristics of the support group itself to be able to better understand the nuances of both the breastfeeding support group and the personal experiences of the mothers attending the group. The combination of ethnography and phenomenology provides the unique opportunity to address these important facets of the physical group as well as the experiences of the women seeking support from the group.

Research Questions

The research questions addressed in this study are as follows:

1. What are the lived experiences of women participating in a healthcare professional facilitated face-to-face breastfeeding peer support group?

2. What aspects of the group influenced the individual experiences of women participating in the group?
3. What are common themes experienced by women participating in the healthcare professional facilitated face-to-face breastfeeding peer support group?

To stay in line with the tenants of ethnography, specific research questions were not identified prior to data collection. As outlined by James Spradley (1980), research questions emerged from field observations. Specifically, questions related to interactions between group members, interactions with the facilitators, quality and type of support received at the group, the processes and structure of the group, and the group environment were relevant in both ethnographic observations and phenomenological interviews. Each woman had different personal reasons for seeking the group, but there was a shared desire for support and connection during this time. Additionally, this qualitative design allowed adjustments to be made after the group discontinued meetings due to the COVID shutdown in March 2020. The interruption brought an end to the participant observations, but the combined methods of this study allowed for adjustments to be made to be able to accommodate real-like changes like this. Though the observations stopped, valuable insights and meaning were brought to light by the interviews.

Theoretical Lens

This study was guided by the philosophical tenants of phenomenology and the theoretical lens of symbolic interactionism and transformative learning. Phenomenology not only influenced the methodology but also the perspective and values that guided the understanding and analysis of the data collected. Symbolic interactionism was used in conjunction with phenomenology to obtain a deep understanding of not only the shared lived experience of the women but also the beliefs that influenced these experiences. Transformative learning theory was used as a means to

derive a deeper understanding of the findings and to add meaning to the metamorphosis process. The purpose of this study was to obtain a better understanding of a face-to-face healthcare facilitated breastfeeding peer support group. With the emergence of the global COVID-19 pandemic, it became increasingly important to utilize flexible and emergent methods and a theoretical lens that provided a deep understanding of not only the processes of the group, but also the significance of participating and experiencing the group through the voice of the participants.

Phenomenology

Phenomenology serves as much more than just a philosophical lens, it also provides guidelines and standards for the ways in which data is collected, how participants are interacted with, how the data is analyzed, and how the researcher presents the shared lived experiences of the participants (Sohn et al., 2017). Specifically, this study followed the procedures outlined by the University of Tennessee Phenomenology Research Group for conducting and analyzing within the scope of phenomenology (Sohn et al., 2017).

Human Experience. Existential phenomenology has its roots in philosophy. This methodology is grounded in the idea that understanding and explaining the world and humans cannot be done from the outside (Matthews, 2006). Understanding breastfeeding rates and practices has largely been examined from the "outside" which leaves a large gap in the understanding of the experiential and personal aspects of the breastfeeding relationship. Merleau-Ponty claims that objective forms of understanding are only accomplished through human activities performed for particular purposes (Merleau-Pony, 2002). Thus, any form of scientific knowledge must be understood in terms of the human experience (Merleau-Pony, 2002). Breastfeeding is not only a purpose driven relationship but also it is a personal relationship that

often includes intentional acquisition of support from other individuals. Thus, according to the ideals of Merleau-Ponty, it could be argued that breastfeeding support is best understood by obtaining extensive information from breastfeeding mothers who actively sought a support relationship. As stated by Merleau-Ponty, all meaning is derived from the human experience of the world around them. That is, all concepts we use to ascribe meaning to the world originate from human experience (Merleau-Ponty, 2002). As a result, Merleau-Ponty claims that human experiences are the absolute source of meaning (Merleau-Ponty, 2002).

According to this philosophical approach, universal conversations about the world in objective terms originate from personal encounters with the world (Merleau-Pony, 2002). Therefore, the human experience and meaning is defined by people living in the world rather than theorizing about it (Matthews, 2006). Thus, in order to obtain understanding of the world around us we must get back to the root of existence itself, which is reliant on the lived experiences of humans (Merleau-Ponty, 2002). As a result, existential phenomenology is a methodology that is committed to setting aside any preconceived ideas and remaining focused directly on the human experience, which, according to Merleau-Ponty, is the quintessential means of understanding the world. If we want to understand the world, or in this case the relevance and importance of a healthcare professional facilitated face-to-face peer support group, we must relearn how to look at the world through the lived experiences of those who participated in such a group (Merleau-Ponty, 2002).

Constructing Meaning. Phenomenology studies the different tools that humans use to understand and relate with the world and people around them (Matthews, 2006). Merleau-Ponty argued that we need to interact with the world unconsciously before it can be explicitly talked about and reflected upon (Merleau-Ponty, 2002). If we want to learn or obtain a higher level of

knowledge we must separate from our pre-existing truth and allow a new perspective to lead us to new truth about the world around us (Matthews, 2006). Phenomenology is uniquely suited to investigate breastfeeding support groups because of the group's unique ability to include both individual experiences and the interactions between the women and healthcare professionals participating in the group. If we hope to better understand breastfeeding rates and how to adequately support the breastfeeding relationship, we must first understand the individual and interactive experiences of women seeking breastfeeding support. To derive meaning from experiences, we must allow ourselves (and the subjects of our study) to first interact with the environment without any conscious or subconscious motives before we try to ascribe any meaning or understanding of our world and our experiences. To hold true to the purpose of this study, women were able to seek support and actively participate in the support group on their own volition before they were asked to reflect and speak about their experiences in the support group.

Phenomenology combines both the subjective and objective to provide meaning. This method acknowledges that all experience is subjective due to the fact that it is someone's experience and is therefore understood by how they appear to a particular subject (person). Additionally, phenomenology recognizes that it is necessary for people to interact and be involved with the world around them and is therefore objective due to the fact that the world continues to exist outside of our experiences with it. Using phenomenology allowed the researcher to investigate the subjective emotional experiences of the women in the group but also the objective advice and techniques mothers received from the group. Phenomenology is the study of essence that does not aim to explain or analyze, but rather its purpose is to describe the essence of being within a particular experience (Merleau-Ponty, 1996). Therefore,

phenomenology was used to guide this study as a way to best approach the reality of the women existing within the particular experience of participating in the support group. To obtain a thorough understanding of a healthcare facilitated face-to-face peer breastfeeding support group it is vital to acquire the perceptions and experiences of the women who sought support from this group.

Symbolic Interactionism

In conjunction with the philosophical lens of phenomenology, this dissertation used symbolic interactionism as a theoretical lens. These two lenses are similar in the ways in which they influence the analysis of the data and the ways in which the researcher communicated and understood the shared voice of the participants, but they differ in the depth in which they influenced the study as a whole. Phenomenology dictated how the interviews were conducted as well as the guidelines for analysis (Sohn et al., 2017). The tenants of symbolic interactionism line up with the philosophical properties of phenomenology. Both symbolic interactionism and phenomenology deal with the ways in which the human experience dictate meaning of and interaction with the world around them, which is why they were used to derive meaning from the lived experiences of mothers participating in a breastfeeding support group. Specifically, symbolic interactionism is the study of human life and behavior (Blumer 1986), which makes it particularly relevant to qualitative breastfeeding studies. There are three basic principles: humans act according to the meaning things have to them, their meanings are derived from social interactions and these meanings are utilized in an interpretive process that aids in future encounters (Blumer, 1986). All three of these principles are relevant to the experiences of women participating in a breastfeeding support group due to the fact that breastfeeding is a personal choice, mothers in this study were seeking social interactions through the support group

and the relationships from this group have the ability to influence the future breastfeeding choices and practices of the mothers who attended the group.

Both phenomenology and symbolic interactionism stress the importance of how humans derive meaning from the world around them. Symbolic interactionism focuses on the idea that humans base their actions off the meanings they have of particular things in the world (Blumer, 1986). It is important to focus on these meanings in order to form a deeper understanding of behavior (Blumer, 1986). If the goal is to better understand breastfeeding practices and breastfeeding support, it is important to investigate the meanings women ascribe to their experiences breastfeeding and seeking and/or receiving support. If we focus on the factors that may lead to a particular behavior, we are neglecting the significance of meaning driving these behaviors. For example, if we ignore how people define and understand the things they are acting towards then we are in essence ridding the behavior of meaning and therefore significance (Blumer, 1986). Symbolic interactionism was used in an effort to surface the ways in which mothers define and understand their actions and experiences towards breastfeeding and breastfeeding support.

Interactions and Interpretation. The source of meaning is derived from interactions. In the case of symbolic interactionism, the physical make-up of things is not how meaning is obtained, but rather it emerges from individuals' interactions with humans and things within this world (Blumer, 1986). This theoretical lens is particularly appropriate for understanding a breastfeeding support group due to the social and interactive nature of both breastfeeding and the support group. Not only does meaning arise from the ways in which an individual interacts with that particular thing, but also it develops from the ways other individuals interact with that particular thing or how individuals interact with each other regarding that particular thing

(Blumer, 1986). Thus, symbolic interactionism views meanings as byproducts of social relations and actions (Blumer, 1986). This idea is mirrored in phenomenology with the idea that all meanings are derived from our ability to interact with the world around us. Furthermore, phenomenology emphasizes the importance of connections with others and the relationships in which individuals' lives are lived (Sohn et al., 2017). The combination of these two lenses allowed for a rich description of how the experiences of breastfeeding mothers influence the meanings they create. Phenomenological interviews and ethnographic observations provided a unique opportunity to see the ways in which women acted within a certain context, how other women acted towards each other within this same context in addition to an extensive account of the personal meanings and experiences of these women.

Symbolic interactionism emphasizes that meanings are generated through a process of interpretation (Blumner, 1986). The interpretive process has two steps: the actor brings awareness to the things he is acting on and self-communicating becomes a means of generating and organizing meanings (Blumer, 1986). First, the actor has to become aware of the things that have meaning, and the recognition of these meanings is a form of self-interaction (Blumer, 1986). Through the process of self-communication, the person is able to reorganize and reform meanings within particular contexts (Blumer, 1986). This interpretation is not an automatic prescription of previous meanings but rather it is a process that provides guidance for the formation of actions (Blumer, 1986). In order to derive meaning from the world around us, we must pay attention to both the space and place, security and freedom, and all other objects and things humans encounter in the world (Tuan, 1977). Employing participant observations along with phenomenological interviews as the central data source allowed a holistic picture of the context in which these women experienced breastfeeding support within a face-to-face support

group. The participant observations served as a means to enter the field and build a sense of trust with the mothers prior to interviewing them.

Transformative Learning

The interpretations of the findings were further understood through the application of transformative learning theory. Transformative learning describes and defines the process by which adults change their "frame of reference" (Mezirow, 1997). Our frames of reference influence the ways in which we define our world through our values, feelings, automatic responses, relationships, and concepts (Mezirow, 1997). Phenomenology and participant observations were utilized in efforts to uncover the ways in which the mothers in the group derived meaning from their experiences and surface their values and beliefs surrounding breastfeeding and the support group. Transformative learning further emphasized the importance of the particular aspects of the group that aided in the destruction and reconstruction of the participants frames of reference surrounding breastfeeding.

Transformative learning suggests that frames of reference help define our assumptions which help individuals understand their experiences (Mezirow, 1997). As a result, individuals form their expectations, perceptions, thoughts, and feelings based on their frames of reference (Mezirow, 1997). In order to obtain a better understanding of the participants experiences, it is important to explore the expectations of the mothers in the group as well as their perceptions, beliefs and thoughts surrounding their experiences participating in the group. The methods used in this study led to rich descriptions of both the observed group experience as well as an in-depth personal account of the mother's perceptions of their breastfeeding relationship and how this relationship was transformed through participation in group. The collective story told by the mothers was further understood by first considering the frame of reference mothers entered their

breastfeeding journey with and then noting how their frame of reference changed over time with their participation in the group.

Transformative learning theory argues that frames of reference are transformed by reflecting on the assumptions with which our perspectives, beliefs and points of view are grounded (Mezirow, 1997). The support group in the present study provided mothers with a safe space to reflect on and communicate with other mothers about their breastfeeding experiences. Meaning is created as a result of social processes with meaningful dialogue (Mezirow, 1997). The environment of the group encouraged mothers to interact with each other and engage in thoughtful conversations about their breastfeeding journey. Participant observations and interviews allowed these interactions to be observed from the outside and reflected upon in the interviews. This combination of methods aids in recognizing the significant conversations that shaped the way mothers understood their breastfeeding relationship.

Outline of the Dissertation

This dissertation utilized two different research methods to examine a healthcare provider facilitated face-to-face peer support group and follows a traditional format. The following chapters have been organized in an effort to demonstrate the importance of breastfeeding, the impact of breastfeeding support, gaps in the literature, the value and appropriateness of the selected methods, results from the data collected, and a discussion of the implications of this research. Specifically, the following chapters are included in this dissertation: Chapter 2: Literature Review, Chapter 3: Methods, Chapter 4: Results, and Chapter 5: Conclusion and Discussion.

The literature review provides a thorough discussion of relevant breastfeeding literature as well as relevant literature related to the selected methods for this dissertation. Specifically,

Chapter 2 covers the benefits of breastfeeding, breastfeeding recommendations and rates, factors influencing breastfeeding rates, breastfeeding support, and a review of phenomenology and ethnography in this area of research. The section on breastfeeding benefits discusses the benefits for both the mother and the infant as well as short-term and long-term breastfeeding benefits. Additionally, this section discusses the importance of the unique qualities of breast milk. Due to the benefits associated with breastfeeding, there are specific guidelines and recommendations for breastfeeding. Thus, there is a comprehensive discussion of these recommendations and the current breastfeeding rates in relation to these recommendations in Chapter 2. Breastfeeding is a complex and personal experience; thus, it is important to consider what factors influence breastfeeding rates. When considering breastfeeding rates, it is impossible to ignore breastfeeding support. Specifically, this section includes a thorough look at the literature related to familial support, online support and in-person support. Lastly, this chapter provides a comprehensive look at the relevance and appropriateness of using phenomenology and ethnography to study breastfeeding.

Chapter 3 provides a description of the methods used to collect data. Two methods were used in an effort to present a rich description of the support group studied as well as a comprehensive report of the shared experiences of the women participating in the group. This section discusses the ways in which the group was observed, when the group was observed and what tools were used during the observations. It also details the techniques used for the interviews with participants. Additionally, this section discusses the processes used to analyze all of the collected data.

Chapter 4 covers the results of the study. It utilizes specific quotes from participants to support the findings as well as details from the initial ethnographic observations during group

meetings. All results from the interviews are confirmed through the University of Tennessee Phenomenology group and are discussed in the language of the participants in an effort to present an all-inclusive view of the lived experiences of the women attending this group. The results from the observations offer a picture of the physical and emotional structure of the group as well as the values, practices and culture within the group. Themes from the observations were confirmed with key informants from the group including the facilitators and the participants. After the reports of these findings, there is a summary of the implications, relevance and conclusions of the study in Chapter 5. This chapter also provides a discussion about the results as they relate to current research and future research. This section demonstrates the importance of this research as it related to future research, practice and policy.

Key Terms

Breastfeeding is a multidimensional experience that is accomplished in many different ways. The following terms are defined as they are used for this dissertation:

Breastfeeding. Is the act of feeding an infant with breast milk.

Initiation. Refers to putting newborns to the breast (United Nations Children's Fund (UNICEF), WHO 2018).

Duration. The length of time the infant consumes breastmilk as a form of nutrition.

Exclusive breastfeeding. Refers to an infant that is only fed breast milk and no other foods or liquids, except for medications or vitamin and mineral supplements (CDC, 2018b).

Complementary foods. When an infant is consuming food other than breastmilk (CDC, 2018b).

Healthcare Provider. All healthcare providers in this study are Registered Nurses (RN) and International Board-Certified Lactation Consultants (IBCLC).

Facilitator. Refers to the professionals that are responsible for organizing the group meetings. They are responsible for providing the space for meetings as well as all necessary tools (hand sanitizer, infant scale, chairs, tables, etc.). Furthermore, these professionals were responsible for maintaining the integrity, privacy and respect of the women attending the group.

Support Group. A group of women and professionals that gather for a common goal of helping women accomplish breastfeeding goals as well as provide both emotional and physical support for the breastfeeding relationship.

Face-to-face. Refers to a support group that meets in-person rather than online or over the phone.

Nipple shield. A thin silicone nipple that mom's wear over their nipple during a feeding.

Tongue tie. A condition that limits the range of motion of an infant's tongue, which can impair the infant's ability to fulfill basic feeding functions such as swallowing and latching (Kotlow, 1999).

Lip tie. When an infant's lip is attached to their gums, which can cause difficulty obtaining a proper latch (Kotlow, 2013).

Infant scale. A scale designed specifically to accurately weigh infants.

Let down. A psychosomatic reflex that influences the expulsion of milk (Newton & Newton, 1950).

Latch. Involves the placement of the lips and tongue on the mother's breast so that the infant can suckle to receive nutrition from the breast (Cadwell, 2007).

Chapter 2: Literature Review

Breastfeeding is associated with a wide range of benefits for both mothers and infants. Currently, most infants in the United States (US) are not breastfed exclusively for the recommended six months (CDC, 2020). There are a number of factors that influence mothers' choices and ability to successfully breastfeed their infant/infants (Eidelman et al., 2012). Extensive research has been done on peer support and health care provider support for breastfeeding mothers (Arora et al., 2000; Brodribb, Fallon, Hegney & O'Brien, 2007; Burns & Schmied, 2017; Burns, Fenwick, Sheehan & Schmied, 2016; Dennis, Hodnett, Gallop & Chalmers, 2002; Foster, Slade, & Wilson, 1996; Kong & Lee, 2004; for review see McInnes & Chambers 2008; Rempel, 2004; Schmied, Beake, Sheehan, McCourt & Dykes, 2011). Though there is extensive research on these topics, there is very limited information about combined support from both peers and healthcare providers in the same group setting. The purpose of this dissertation is to explore a face-to-face breastfeeding peer support group facilitated by health care professionals in the Southern region of the US. Specifically, the structure, values and norms of the group are described as well as the in-depth lived experiences of the women who participated in this group.

Benefits of breastfeeding

Breastmilk is uniquely suited to meet human infants' nutritional needs and has the added benefits of unparalleled immunological and anti-inflammatory properties that protect both the infant and mother from a number of illnesses and diseases (Lawrence & Lawrence, 2010). A meta-analysis revealed that children who were breastfed exclusively and for longer periods of time, when compared to infants who were never breastfed or breastfed for a short amount of time, had a decreased risk for lower respiratory tract infections, asthma, childhood leukemia, and

Sudden Infant Death Syndrome (Chung et al., 2007). Additionally, oxytocin, a hormone released by the suckling of the infant, ignites uterine contractions that help prevent postpartum hemorrhaging and aids in returning the uterus to the non-pregnant state (Dermer, 2001). Furthermore, breastfeeding delays the return of menstrual periods, which allows the mother to conserve iron as well as aiding in a natural space between pregnancies (Dermer, 2001). Women who have never breastfed are at a higher risk of breast cancer and are at a 27 percent higher risk of having ovarian cancer than those women who breastfed for a period of time (Bernier et al., 2000; CGHFBC, 2002; Chung et al., 2007).

Benefits associated with breastfeeding appear to be long-lasting for both mother and infant. In a systematic review of the long-term effects of breastfeeding, the WHO found that breastfeeding has been associated with a reduction of death due to infectious diseases in childhood (for review see Bernardo, Cesar & WHO 2013). Additionally, there were significant associations between breastfeeding and the reduction of obesity, blood pressure and type-2 diabetes both in childhood and later in life (for review see Bernardo, Cesar & WHO 2013). A meta-analysis found an increase in infant mortality in infants who were not breastfed and a decreased mortality and hospitalization rates in infants who were breastfed for at least 3 months (Binns, Lee & Low, 2016). Mothers who have breastfed experience reduced risks of ovarian cancer, reduced premenopausal breast cancer, reduced obesity, type 2 diabetes and heart disease (Binns, Lee & Low, 2016). A study using data from the Women's Health Initiative Study reported that women with a lifetime history of 12 or more months of lactation, compared to women who never breastfed, was associated with hypertension reduction, reduced diabetes, reduced hyperlipidemia and reduced cardiovascular disease in women who were 50-59 years of age (Schwarz et al., 2009). This reduction in hypertension, diabetes, hyperlipidemia and

cardiovascular disease decreased when women reached 60-69 years of age but remained the same if women in this age range had breastfeed for 13-23 months throughout her lifetime (Schwarz et al., 2009). It is important, however, to note that there are confounding factors that influence the rates of disease early and later in life, thus more studies are needed to better disentangle these factors.

In addition to the many health benefits associated with breastfeeding, there are also developmental benefits related to breastfeeding. A longitudinal study from Brazil with a 3-decade follow up that had 3,493 participants and controlled for factors such as maternal education, household income and maternal age, found relationships between breastfeeding for 12 months or longer and cognitive development (Victora et al., 2015). Specifically, the duration and regularity (breast milk as the main form of nutrition) of breastfeeding were positively associated with increased IQ, educational attainment and income later in life (Victora et al., 2015). Similarly, in a prospective cohort study in Singapore, 212 infants underwent 3 neurocognitive tests at 6,18 and 24 months of age (Cai et al., 2015). After controlling for potential confounding variables such as, ethnicity, maternal age and maternal antenatal anxiety scores, infants with higher breastfeeding exposure tested higher in neurocognitive tests at 6 months and 24 months (Cai et al., 2015). For the purposes of this study, infants were considered as having high breastfeeding if they were exclusively or mostly breastfed until four months and continued breastfeeding until six months or beyond (Cai et al., 2015). Higher levels of breastfeeding exposure was related to better memory at 6 months and at 24 months, infants were more likely to display sequential memory skills, score higher in receptive language skills, and expressive language skills when compared to infants with lower breastfeeding exposure (Cai et al., 2015).

These positive developmental outcomes associated with breastfeeding are encouraging, it is important to consider other variables that might influence these outcomes.

Though there is an association with breastfeeding and cognitive development, it is worthy to look into breastfeeding rates and how these characteristics might influence cognitive development. Considering these confounding factors helps us to better understand the multitude of ways in which infant development can be supported. Mothers with higher education levels and with a higher household income are more likely to breastfeed and to breastfeed for the recommended duration when compared to mothers with lower education levels and with a lower household income (CDC, 2018a). Thus, it could be argued that children with high levels of breastfeeding exposure are more likely to have access to resources and environments that support cognitive development. For instance, a longitudinal survey of early childhood (N = 7,500) that examined the impact of infant feeding practices and cognitive development in early childhood found that cognitive skills were related to cognitively supportive parenting and greater levels of education among the women who primarily breastfed (Gibbs & Forste, 2014). Specifically, the infant feeding practices were not found to be related to higher levels of cognitive development, but rather the parenting practices such as reading to their child and being sensitive to their child's needs were a significant predictor of cognitive development (Gibbs & Forste, 2014). Current research has conflicting results when it comes to breastfeeding and developmental outcomes, which is why it is important to note that these factors are complicated and difficult to tease apart. Overall, research has indicated that breastfeeding is one of many factors that positively influences the development and health of infants and children.

Breastfeeding recommendations and rates

Due to the benefits associated with breastfeeding, the WHO and the AAP both recommend exclusive breastfeeding for 6 months (Eidelman et al., 2012; WHO, 2018). While both organizations recommend complementary foods after 6 months of age, the AAP recommends breastfeeding along with complementary foods for at least 12 months and the WHO recommends breastfeeding along with complementary foods for at least 24 months (Eidelman et al., 2012; WHO, 2018). The WHO and AAP have differing recommendations for total breastfeeding duration, but there is consensus on the recommendation that infants should be exclusively breastfed for the first 6 months of life. Though there is extensive research on the benefits associated with breastfeeding for both mothers and infants, most infants in the United States are not exclusively breastfeed for the recommended six months (Centers for Disease Control and Prevention (CDC), 2018a).

The 2020 Breastfeeding Report card revealed that, among infants born in 2017 in the United States, 84.1% initiated breastfeeding, 58.3% of infants were breastfeeding at 6 months, and 35.3% of infants were breastfeeding at 12 months (CDC, 2020). High initiation rates suggest that women may intend to breastfeed but are unable to meet the recommendation to exclusively breastfeed for 6 months (CDC, 2020). In fact, less than 50% of infants were exclusively breastfed through 3 months and 25.6% were exclusively breastfed though 6 months (CDC, 2020). Though most infants are not exclusively breastfed for the recommended 6 months, it is important to note the progress in breastfeeding rates. Healthy People 2020 is a federal government agenda for building a healthier nation through the establishment of goals and monitored progress over time (U.S. DHHS, 2013). When looking specifically at breastfeeding, this initiative aimed to increase the proportion of infants ever breastfed, breastfed at 6 months,

breastfed at 1 year, exclusively breastfed through 3 months and exclusively breastfed through 6 months (U.S. DHHS, 2013). According to the 2020 Breastfeeding Report Card (CDC, 2020), the U.S. has exceeded the goal (81.9%) for increasing infants who are ever breastfed to 84.1%, the goal (34.1%) of infants breastfed at one year to 35.3%, and the goal (46.2%) for infants being breastfed exclusively through 3 months 46.9%. These improvements are encouraging, but there is still room for improvement.

Children living in certain regions of the country, racial minority children, children living in poverty and children with less educated parents are less likely to be breastfed and to be breastfed for the recommended duration (CDC, 2018a). Specifically, infants living in the Southeast are 10-20% less likely to be breastfed at 6 months when compared to infants living in other regions of the country (CDC, 2020). Infants living in rural areas are roughly 6% less likely to ever be breastfed when compared to infants living in urban areas (CDC, 2020).

According to the 2020 Breastfeeding Report Card, non-Hispanic Black infants (73.7%) are less likely to ever be breastfed when compared to Asian infants (90%), non-Hispanic White infants (86.7%) and Hispanic infants (84.1%) (CDC, 2020). Specifically73.7% of non-Hispanic Black infants born in 2017 were ever breastfed and only 21.2% were exclusively breastfed for 6 months (CDC, 2020). Non-Hispanic Black infants are roughly 14% less likely than non-Hispanic White infants to be breastfed at 6 months, roughly 12% less likely at 12 months, and are roughly 14% less likely to be exclusively breastfed at 3 months (CDC, 2020). These disparities are least evident when looking at breastfeeding rates for infants exclusively breastfed through 6 months with only a 7% difference (CDC, 2020). Non-Hispanic Asian mothers had roughly 4% higher initiation rates than non-Hispanic White mothers, 12% higher rates at 6 months, and 12% higher rates at 12 months (CDC, 2020). This relationship reverses when looking at exclusive rates, with

non-Hispanic White mothers being 5% more likely to exclusively breastfeed for 3 months and 2% more likely to exclusively breastfeed at 6 months (CDC, 2020).

Breastfeeding disparities are also associated with maternal levels. Mothers with less than a high school degree were 20% less likely to initiate breastfeeding and 15% less likely to exclusively breastfeed for 6 months when compared to mothers with a college degree (CDC, 2020). Mothers with high school degrees were 18% less likely to initiate breastfeeding and 11% less likely to exclusively breastfeed for 6 months when compared to mothers with a college degree (CDC, 2020). While there is a slight increase between mothers with less than a high school degree and a high school degree it is important to note that as maternal education increased the breastfeeding rates also increased. The only exception occurs with mothers having less than a high school degree were 5% more likely to breastfeed at 6 months and 3% more likely to breastfeed at 12 months when compared to mothers with a high school degree (CDC, 2020). Thus, it would appear that high levels of education are associated with higher breastfeeding throughout the first year of life.

Disparities in breastfeeding rates are present in mothers with differing income levels. Infants who are eligible for and receiving Special Supplemental Nutrition Program for Women, Infants and Children (WIC) are less likely to ever be breastfed when compared to other infants. Specifically, infants receiving WIC are 5% less likely to be breastfed than infants who are eligible but not receiving WIC and are 15% less likely to be breastfed than infants who are not eligible for WIC (CDC, 2020). Infants living in poverty are 7% less likely to ever be breastfed than the average infant in the US, while infants in the highest income bracket are 9% more likely to be breastfed than the average infant in the US (CDC, 2020). As income increases, so do

breastfeeding rates at 6 moths and 12 months (CDC, 2020). Furthermore, income is positively associated with exclusive breastfeeding rates at 3 and 6 months (CDC, 2020).

Maternal work environment and requirements can serve as a large barrier to breastfeeding. Currently, the U.S. does not provide paid leave for new mothers. Although the US does not offer federally mandated paid leave for non-federal employed parents, it is notable that some workers in the US have access to generalized leave from work (U.S. Bureau of Labor Statistics (USBLS), 2019). In 2017-2018, 66% of wage and salary workers had access to paid leave at their jobs, 78% of wage and salary workers had access to unpaid leave and 9% of wage and salary workers were unsure (USBLS, 2019). In total, 93% of workers had access to paid or unpaid leave (USBLS, 2019). More specifically, 65% of working women and 67% of men had access to paid leave (USBLS, 2019). Among individuals working full-time with one job, those with a higher pay had greater access to paid leave. Specifically, 86% of workers in the top 25% of earners had access to paid leave, while 57% of workers among the lowest 25% of earners had access to paid leave (USBSL, 2019). Given these percentages, it is more likely that mothers with lower household incomes might not have paid leave options or be able to afford missing work in order to maintain a breastfeeding relationship.

Although 51% of employers offer a worksite lactation support programs (CDC, 2020), mothers returning to work often face inflexibility in work hours and locations, lack of privacy for breastfeeding or pumping, have no place to store breast milk, inability to find childcare facilities at or near their workplace, job insecurity, and limited maternity benefits (Guttman & Zimmerman 2000; Hawkins, Griffiths, Law & Millennium Cohort Study, 2007; Johnston & Esposito, 2007; Kimbro, 2006). Data from a national survey of women ages 18 to 45 who gave birth in 2011 and 2012 revealed that only about 40% of women had access to both break time

and private space (Kozhimannil et al., 2016). These survey results revealed that women with both adequate break time and private space were 2.3 times as likely to be breastfeeding at 6 months and 1.5 times as likely to continue breastfeeding exclusively with each passing month when compared to women without these accommodations (Kozhimannil et al., 2016). Additionally, a national sample of the three largest cities in each state in the U. S. (including Washington, DC) revealed that only 2 of the 151 (1.3%) cities had specific legislation outlining protections for breastfeeding women in the workplace (Froh et al., 2018). Thus, work environment has the potential to influence the duration and exclusivity of breastfeeding. In order to increase breastfeeding rates, it is essential to better understand what factors influence mothers breastfeeding decisions and ability to maintain a breastfeeding relationship.

Factors influencing breastfeeding rates

Many factors influence a mother's decision to initiate and ability to maintain breastfeed including, but not limited to, peer support, social context, and perceived support from husbands/partners (Arora et al., 2000; Brodribb, Fallon, Hegney & O'Brien, 2007; Dennis, Hodnett, Gallop & Chalmers, 2002; Foster, Slade, & Wilson, 1996; Kong & Lee, 2004; Rempel, 2004). Women appear to make infant feeding decisions early in pregnancy; in fact, data from a longitudinal study with 317 Canadian mothers and survey results from 245 mothers in northwestern Pennsylvania indicated that the decision to breastfeed was made within the first trimester of pregnancy (Arora et al., 2000; Rempel, 2004). Similarly, a longitudinal assessment of prenatal breastfeeding intentions and actual breastfeeding duration of 317 mothers revealed that prenatal breastfeeding intentions were significantly correlated to actual breastfeeding duration (Rempel, 2004).

Many women in the US are, in general, aware of the benefits to breastfeeding, but lack the knowledge about specific benefits and are unable to explain the risks associated with not breastfeeding (Gibson, 2005; Li, Rock, & Grummer-Strawn, 2007; McCann, Bayday & Williams, 2007; Thulier & Mercer, 2009). For example, a national sample of women enrolled in WIC reported that only 36% of participants believed breastfeeding would protect the infant from diarrhea (McCann et al., 2007). Some people, including health professionals, believe that formula is equivalent to breast milk in terms of health benefits because formula has been fortified with vitamins, minerals, as well as other ingredients such as DHA and ARA (Gibson, 2005; Li et al., 2007). Although formula has been enhanced to mimic nutritional properties of breastmilk it remains constant, the composition of breast milk changes to adapt to the infant's nutritional and immunological needs, which is one of the reasons why it is considered the ideal source of infant nutrition (Picciano, 2001). A national survey revealed that 31% of U.S. adults believed infants should be fed cereal or baby food by age 3 months (Li, Fridinger & Grummer-Strawn, 2002). Introducing infants to other food sources early has potential to weaken the breastfeeding relationship. Specifically, if infants are getting their nutritional needs met from other sources it is likely that their intensity and frequency of latching will decrease which can decrease the demands on the breast and subsequently decrease the breast milk supply (Li, Fridinger & Grummer-Strawn, 2002).

Though exclusive breastfeeding up to 6 months is recommended by the AAP, some mothers are uncertain about how to successfully breastfeed and what to expect while breastfeeding (U. S. DHHS, 2011). A disconnect between mother's expectations and actual experiences has been associated with early cessation of breastfeeding (Moore & Coty, 2006; Mozingo, Davis, Droppleman & Merideth, 2000; O'Brien, Buikstra & Hegney, 2008; U. S.

DHHS, 2011). Additionally, a national survey revealed that almost half (45%) of U.S. adults believed that breastfeeding required mothers to give up too many lifestyle habits (Li, et al., 2002). Thus, a lack of knowledge on breastfeeding, the differences between breast milk and formula and what to expect while breastfeeding serve as barriers to mothers' ability to successfully breastfeed their infants.

Breastfeeding Support

When considering factors that influence breastfeeding rates it is important to consider breastfeeding support. Several studies have looked at the influence of breastfeeding support and the different sources of support including, but not limited to, familial support, father support, peer support, face-to-face support, support groups, virtual support and healthcare provider support (Arora et al., 2000; Brodribb et al., 2007; Burns, Fenwick, Sheehan & Schmied, 2016; Burns & Schmied, 2017; Dennis et al., 2002; Foster et al., 1996; Kong & Lee, 2004; for review see McInnes & Chambers 2008; Rempel, 2004). A systematic literature review assessing the impact of different support sources found that support from professionals increased breastfeeding duration (though not exclusivity) and peer support had a significant positive influence on exclusive breastfeeding rates (for review see Sikorski, Renfrew, Pindoria & Wade, 2003). As indicated, there are different forms and sources of support for breastfeeding mothers and it is important to consider how these impact mothers.

Family Support. The role of the family should not be ignored when considering breastfeeding support. A metasynthesis including both formal and informal breastfeeding support found that women considered authentic and individualized support from people they trust to be most effective (Schmied et al., 2011). Family members are often trusted individuals who have the opportunity to provide authentic and individualized breastfeeding support for mothers; thus,

family members are influential, both good and bad, when considering breastfeeding rates. A study with 597 mothers which assessed 26 variables during the postpartum period at discharge, 1 month, 4 months, and 6 months found an increase in the duration and frequency of exclusive breastfeeding at 6 months in the mothers who reported good or very good family support (Cernadas, Noceda, Barrera, Martinez & Garsd, 2003). Furthermore, this association between family support and exclusive breastfeeding rates at 6 months remained after controlling for maternal education and duration of prior breastfeeding relationships (Cernadas et al., 2003). A study investigating the feasibility of a prenatal breastfeeding intervention for grandmothers and fathers found that mothers who had support from a trained family member were more likely to be breastfeeding at eight weeks when compared to mothers who didn't have trained family members (Ingram & Johnson, 2004).

It is critical to consider the family support system mothers have during their current breastfeeding relationship regardless of prior experiences. Familial support, in general, is valuable for the breastfeeding relationship, but there has been particular interest in the role of fathers in breastfeeding rates and experiences. A qualitative study that utilized focus groups with mothers and interviews and surveys with fathers to investigate breastfeeding support identified "Dads do make a difference" as the major theme emerging from the responses from the 76 participants (Tohotoa, Maychock, Hauck, Howar, Burns & Binns, 2009). Mothers discussed the importance of fathers anticipating the needs of mothers, encouragement from fathers to do their best and fathers identified wanting to be involved as their main motivation to learn more information about breastfeeding and to be an advocate for breastfeeding (Tohotoa et al., 2009). Thus, it is critical to realize that though fathers aren't actively breastfeeding, they do play a major support role for breastfeeding mothers.

Though family has the potential to fill significant support roles that are beneficial to the breastfeeding relationship, it is also relevant to note that family dynamics can also hinder breastfeeding (Asiodu, Waters, Dailey & Lyndon, 2017). For instance, a survey study with 123 mothers found that mothers who bottle fed reported they would have been encouraged to breastfeed if they had received more support from family members and that the primary reason for choosing bottle feeding over breastfeeding was their perception of the infant's father's preference (Arora, McJunkin, Wehrer & Kuhn, 2000). This research demonstrates the value in not only considering sources of familial support, but also to considering mothers' perceptions of familial preferences.

Online Support. Though the family can play a valuable role in the breastfeeding relationship and breastfeeding rates, not all mothers receive comprehensive support from their family. Not all women have access to or live-in close proximity to family members; thus, it is imperative to consider sources of support that women have easy access to regardless of their familial relationships. A meta-analysis of 16 articles that included e-technology interventions designed to promote, teach and support breastfeeding mothers found that e-technology interventions significantly improved breastfeeding initiation, exclusive duration, breastfeeding attitudes and knowledge (Lau, Htun, Tam & Klainin-Yobas, 2016).

An online ethnography with 15 closed Facebook groups affiliated with the Australian Breastfeeding Association (ABA) captured all wall posts, comments and images over a four-week period and found that these groups provided both informational and emotional support for mothers (Bridges, Howell & Schmied, 2018). The administrators were active in both responding to posts and managing the discussions to ensure that the group discussions adhered to the ABA's Code of Ethics (Bridges, Howell & Schmied, 2018). Additionally, this study found that

breastfeeding management, breastfeeding and health, and breastfeeding and work were the most prominent questions (Bridges, Howell & Schmied, 2018). Specifically, questions related to certain breastfeeding experiences such as timing and frequency of feedings, feeding to sleep, positioning and attachment were discussed in these groups (Bridges, Howell & Schmied, 2018). In other words, these groups allowed for mothers to ask a wide range of questions to other mothers as the questions came up naturally throughout the day.

Mothers not only seek information from the internet, but it is clear that they are also seeking support (Lebron et al., 2020). An online breastfeeding forum with over 140,000 users and more than one million conversation threads was used to extract 258 original posts and 1,445 corresponding comments to examine the information sought and the sharing practices used by members (Lebron et al., 2020). The analysis found that individuals in the group utilized the forum to ask questions about issues related to their breastfeeding experiences (Lebron et al., 2020). Posts were most often related to feeding challenges; more specifically, most original posts dealt with infants' preference for breast versus bottle and posts associated with supply issues both oversupply and undersupply (Lebron et al., 2020). The researchers also analyzed conversation threads and found that most of the content consisted of knowledge (largely advocacy and resources) sharing, experiences, and encouragement (Lebron et al., 2020). It would appear that online groups provide a unique environment in which mothers and other individuals involved can seek personalized information and support.

It is important to not only gain insight into what types of support and information women are seeking from online support, but to also understand the experiences and impacts of online support. A study that utilized interviews to investigate 14 women's experiences using online support for breastfeeding revealed that the mothers were attracted to online support due to a lack

of professional, familial, and partner support (Regan & Brown, 2019). More importantly, these mothers expressed that the online support was reassuring, empathetic, available at all times, and easier than attending an in-person support group (Regan & Brown, 2019). Though these women largely perceived the online support as beneficial they did express negative impacts of this source of support such as judgement for using formula, polarized debates, and lack of regulation resulting in unhelpful information being posted (Regan & Brown, 2019). Another study performed a randomized clinical trial with 215 mother-child pairings (123 assigned to the intervention and 128 to the control group) on an online support group (Cavalcanti et al., 2019). Weekly posters related to different breastfeeding topics and active communication were established in the intervention group's forum and all mothers (control and intervention groups) participated in monthly interviews until their child was 6 months (Cavalcanti et al., 2019). The study found that the mothers who were a part of the intervention had higher frequency of exclusive breastfeeding each month when compared to mothers in the control group (Cavalcanti et al., 2019).

In-Person Support. Though online sources provide a unique space for women to obtain advice, information and emotional support for breastfeeding, they lack the ability to provide physical support. Breastfeeding is an emotional and physical experience; thus, it is important to consider the sources of physical in-person support women receive while breastfeeding. Extensive research has looked at the influence of peer-support through various types of breastfeeding support groups (Arora et al., 2000; Brodribb et al., 2007; Burns & Schmied, 2017; Dennis et al., 2002; Foster et al., 1996; Kong & Lee, 2004; for review see McInnes & Chambers 2008; Rempel, 2004). Limited research has investigated the influence of support groups that include both healthcare professionals and peers. A systematic literature review of mothers' and

healthcare professionals' perceptions of breastfeeding support revealed that women often reported a preference for peer support over professional support (for review see McInnes & Chambers, 2008). This preference for peer support highlights the importance for understanding the types of support women are receiving and how it impacts their breastfeeding experiences and breastfeeding choices.

Unfortunately, support does not always improve breastfeeding rates or experiences. Healthcare professionals have been observed providing feedback that places blame on mothers for breastfeeding challenges or difficult infant behavior (Burns et al., 2016; for review see McInnes & Chambers, 2008). For example, in a synthesis of the breastfeeding support literature, healthcare professionals were found attributing infant problems to mothers' anxiety (for review see McInnes & Chambers, 2008). Healthcare professionals were observed by mothers as being bossy, judgmental, and providing "prescriptive" advice rather than providing emotional support and encouragement for mothers (Burns et al., 2012; McInnes & Chambers, 2008; Schmied et al., 2011). These observations of healthcare professionals suggest that some healthcare professionals may lack a level of emotional sensitivity towards new mothers.

Difficulties encountered during the early phases of the breastfeeding relationship can also serve as barriers to breastfeeding. Early cessation of breastfeeding is often related to inadequate milk supply (real or perceived), latching difficulties, and painful or clogged milk ducts (Bunik et al., 2010; McInnes & Chambers, 2008; Thulier & Mercer, 2009). Mothers encountering these problems are more likely to cease breastfeeding early unless they receive professional assistance (Heinig et al., 2006; Taveras et al., 2003). Additionally, breastfeeding confidence has the ability to greatly influence a mother's ability to successfully initiate and continue breastfeeding despite encountering challenges. In a metasynthesis of informal and formal peer and professional

breastfeeding support, breastfeeding mothers reported healthcare professional support often reduced their confidence in their ability to successfully breastfeed (Schmied et al. 2011). Hill and Humenick (1989) conducted an extensive review of the literature related to insufficient milk supply, which laid the groundwork for the H & H Lactation Scale, a tool used to help understand mothers' perceptions of insufficient milk supply (Hill & Humenick 1996). Using the H & H lactation scale, mothers with lower confidence/commitment scores had lower breastfeeding levels at 6 weeks postpartum (Hill & Humenick 1996). Therefore, it is important to ensure women are receiving support that encourages confidence in breastfeeding mothers.

Peer-based breastfeeding support provides mothers with a different type of resource than healthcare professional-based support. A discourse analysis of both group and individual breastfeeding support interactions revealed that peer support seemed to normalize breastfeeding by making it a part of everyday life (Burns & Schmied, 2017). Additionally, normalizing breastfeeding provided mothers with the expectation that challenges would occur, are normal, and could be overcome (Burns & Schmied, 2017). Peer support also provides mothers with a more experience-based approach as opposed to a knowledge-based approach (Burns & Schmied, 2017). This type of normalized and experience-based approach provides women with a sense of community and connectedness (Burns & Schmied, 2017). Peer support appears to provide mothers with a unique perspective and source of support that most healthcare professionals are either lacking or are unable to provide. It may be an important component to establishing and maintaining a successful and long-lasting breastfeeding relationship.

Extensive research has investigated the importance of peer support for breastfeeding mothers (Arora et al., 2000; Brodribb et al., 2007; Dennis et al., 2002; Foster et al., 1996; Kong & Lee, 2004; Rempel, 2004). A large number of studies have investigated breastfeeding support

provided by healthcare professionals (Burns & Schmied, 2017; Burns et al., 2016; for review see McInnes & Chambers 2008) and how peer support differs from support provided by healthcare professionals (Burns & Schmied, 2017; Burns et al., 2012; McInnes & Chambers 2008; Schmied et al. 2011). However, there is limited research on in-person peer-support groups that include both healthcare professionals and peers. Furthermore, a metasynthesis of qualitative data from breastfeeding mothers revealed that mothers reported the importance of receiving help from multiple sources (Nelson, 2006); a healthcare facilitated peer support group provides a unique opportunity for women to seek more than one source of breastfeeding support in one location at one point in time. It is beneficial to gain insights into experiences of breastfeeding mothers as they navigate infant feeding choices while also participating various types of support groups.

Phenomenology, Ethnography, and breastfeeding

Breastfeeding is a physical, emotional and personal process, which is why it is necessary to gain insights into the lived experiences of breastfeeding mothers. A metasynthesis of qualitative breastfeeding studies revealed that women reported breastfeeding as a highly personal and physical experience that requires maternal commitment, adaptation, and support from multiple sources (Nelson, 2006). Consequently, it is essential to consider how personal and physical experiences influence mothers' breastfeeding decisions. In a phenomenological study on exclusive breastfeeding, mothers reported that exclusive breastfeeding was harder than expected and exclusive breastfeeding is a personal choice that everyone has an opinion about (Charlick, McKellar, Gordon & Pincombe, 2018). Though these mothers reported that breastfeeding was a difficult process that many people had opinions about, they also reported that their determination to uphold their personal beliefs about the benefits of breastfeeding

outweighed these challenges (Charlick et al., 2018). Therefore, when considering breastfeeding support, it is vital to take mothers' perceptions and personal beliefs into account.

Reports of breastfeeding being a personal experience partnered with the benefits of support demonstrates the importance of investigating the impact and perceptions of different sources of support. A phenomenological study including three groups of mothers (exclusively breastfed, successful at breastfeeding (ever breastfed), and not successful at breastfeeding/did not breastfeed) found that mothers attributed their success (or lack of success) to the presence of a breastfeeding role model (Powell, Davis & Anderson, 2014). Furthermore, successful mothers reported the importance of breastfeeding peers and/or peers that are supportive of breastfeeding (Powell et al., 2014). Breastfeeding is a unique experience due to the fact that it is highly personal and sometimes private, yet many external factors and individuals are capable of influencing breastfeeding outcomes.

In a call for best practice in research, scholars Leeming, Marshall and Locke (2017), called for more qualitative methods to explore breastfeeding support interventions. Tremendous efforts have been made to understand the effectiveness of breastfeeding support interventions but have primarily focused on outcomes rather than the relational, organization and contextual processes that influence support interventions (Leeming, Marshall and Locke, 2017). Leeming and colleagues (2017) argue that qualitative data is uniquely suited to aid in the understanding of the complexities involved in breastfeeding support interventions and should therefore be used more to study breastfeeding support interventions. In particular, it is argued that an in depth understanding of the interpersonal and social processes involved with breastfeeding support might be best gained through a combination of phenomenological, ethnographic and discursive methods (Leeming et al., 2017).

Due to the complexities and personal nature of breastfeeding support interventions, it is critical to utilize a method that is able explore this topic through the perspective and perceptions of the breastfeeding mother. In general, outcomes do not give a complete picture of the functionality of the intervention/support in aiding women in their breastfeeding goals and experience (Leeming et al., 2017). Consequently, to obtain a comprehensive understanding of a breastfeeding support group, a combination of phenomenology and ethnography is an ideal method. The in-depth phenomenology interviews will provide considerable insight into the experiences of women, while the ethnographic observations will offer a detailed account of the structure of the group itself as well as the process of gaining entry into the group culture, establishing rapport with participants, and building relationships with cultural informants. This dissertation utilized a combination of phenomenology and ethnographic observations to provide a detailed description of a healthcare provider facilitated face-to-face breastfeeding support group and the lived experiences of individuals participating in the same breastfeeding support group.

Phenomenology

In basic terms, phenomenology is the study of the essential meanings of a phenomenon through the lived experiences of individuals (Merleau-Ponty, 1962; van Manen, 1990). The phenomenon, or the object of human experience (van Manen, 1990), examined in this dissertation is participation in a healthcare professional facilitated face-to-face peer support group. Phenomenology has been utilized to report the lived experiences of breastfeeding mothers. The detailed interviews involved in phenomenology have explored how breastfeeding difficulties influence breastfeeding choices and experiences (Ericson & Palmér, 2019; Guay, Aunos & Collin-Vézina, 2017; Lindberg & Berglund, 2014; Palmér, Carlsson, Brunt & Nyström,

2015; Sulaiman, Liamputtong & Amir, 2016). These studies examined difficulties such as those experienced by mothers with intellectual disabilities trying to breastfeed (Guay, Aunos & Collin-Vézina, 2017), infants born with cleft lip and palates (Lindberg & Berglund, 2014), severe difficulties with early breastfeeding (Palmér, et al., 2015), breastfeeding preterm infants (Ericson & Palmér, 2019) and returning to work (Sulaiman, Liamputtong & Amir, 2016). Though these studies examined a variety of breastfeeding challenges, mothers expressed that support was an indispensable part of their ability to breastfeed (Ericson & Palmér, 2019; Guay, Aunos & Collin-Vézina, 2017; Lindberg & Berglund, 2014; Palmér, Carlsson, Brunt & Nyström, 2015; Sulaiman, Liamputtong & Amir, 2016).

Phenomenological methods have also been utilized in efforts to better understand the feeding experiences of mothers and fathers (Hounsome & Dowling, 2018; Spencer, Greatrex-White & Fraser, 2015; Spencer & Fraser, 2018). Two studies examined the experiences of breastfeeding mothers (Spencer, Greatrex-White & Fraser, 2015; Spencer & Fraser, 2018). In both of these studies the women reported that they felt pressures from healthcare providers and their family, friends and the wider community surrounding their breastfeeding choices (Spencer, Greatrex-White & Fraser, 2015; Spencer & Fraser, 2018). Also, mothers described a certain level of hiding their personal issues surrounding breastfeeding (Spencer, Greatrex-White & Fraser, 2015; Spencer & Fraser, 2018); in one study it was in an effort to not be seen as a failure (Spencer, Greatrex-White & Fraser, 2015) and the other was due to a dislike of the support from healthcare professionals (Spencer & Fraser, 2018). Though the reasoning for hiding their challenges were different, it is important to note that women were not receptive to receiving or asking for support because of their personal perceptions of what the support meant. Lastly, phenomenological interviews with six fathers revealed they didn't feel as though they had as

much say in the breastfeeding decisions as the mother did (Hounsome & Dowling, 2018). These fathers expressed that they felt as though it was appropriate for the mothers to hold more power when it came to breastfeeding decisions (Hounsome & Dowling, 2018). As a result, the researchers in this study proposed that interventions only providing fathers with education and increasing knowledge might not be the best way to prepare fathers for their roles in the breastfeeding relationship (Hounsome & Dowling, 2018). These phenomenological studies reveal the importance of being aware of how perceptions of the roles within the breastfeeding relationship and individual experiences can influence breastfeeding practices. Though there is a wide range of phenomenological studies examining different experiences related to breastfeeding, there is a surprisingly limited number of phenomenological studies that have investigated breastfeeding support groups.

Ethnography

Ethnography is the work of describing a culture (Spradley, 1980). More specifically, ethnography is a way of studying a culture-sharing group by describing the values, behaviors, beliefs and language of that group (Creswell, 2012; Spradley, 1980). For the purpose of this dissertation, culture is defined as the acquired knowledge individuals use to understand experiences and generate behavior (Spradley, 1980). Therefore, breastfeeding support groups form a culture of their own due to the fact that they are a subgroup of women bonded by a shared experience and a set of specific knowledge that informs infant feeding decisions and behaviors. Gaining a better understanding of the behaviors, interactions and shared values of breastfeeding support groups will help inform research on the processes and types of interactions that provide support to new mothers navigating infant feeding choices and experiences.

Ethnographic methods have been used to study various aspects of parenting, including infant feeding choices. Specifically, a few ethnographies have investigated breastfeeding support (Asiodu, Waters, Dailey & Lyndon, 2017; Bridges, Howell & Schmied, 2018; Burns, Schmied, Sheehan & Fenwick, 2010; Flood, 2017). A critical ethnographic study investigated the infant feeding perceptions and experiences of 14 pregnant women and eight support persons (Asiodu, et al., 2017). Mothers and supporters were interviewed during pregnancy and in the postpartum period. Participants reported that their social support played a major role in the continuation or early cessation of breastfeeding (Asiodu, Waters, Dailey & Lyndon, 2017). A study investigating the social support sought by mothers on closed social media groups included 778 wall posts with 2,990 comments revealed that 21% of wall posts were questions and 44% of those questions were specific breastfeeding questions (Bridges, Howell & Schmied, 2018). The groups were hosted by the Australian Breastfeeding Association and were administered and moderated by trained peer breastfeeding counselors (Bridges, Howell & Schmied, 2018). Analysis of these groups revealed that 21% of the posts were questions and 44% of those questions were breastfeeding specific questions (Bridges, Howell & Schmied, 2018). The majority of these questions (76%) were related to breastfeeding management, breastfeeding and health, and breastfeeding and work (Bridges, Howell & Schmied, 2018). The researchers concluded that the social media groups provided both informational and emotional support from both trained peer counsellors and other mothers (Bridges, Howell & Schmied, 2018).

A meta-ethnographic synthesis included 17 studies representing the experiences of 500 women in six western countries (Burns et al., 2010). Two major themes emerged from this meta-ethnographic synthesis; the first dealt with the expectations and realities of breastfeeding and the second revealed the conflicting connection and disconnection associated with breastfeeding

(Burns et al., 2010). Mothers reported that breastfeeding was a natural process that is meaningful and is best for the infant, but the reality of breastfeeding was demanding, and that cessation of breastfeeding was associated with a feeling of guilt and failure (Burns et al., 2010). Furthermore, mothers who had pleasant descriptions of breastfeeding and their subsequent connection with their infant expressed the importance of appropriate support, while women who experienced difficulties and described the experience as negative expressed a lack of confidence and were critical of the support received (Burns et al., 2010). These ethnographic studies expand on the importance of support, but none of them explicitly detailed the experiences of women seeking breastfeeding support. One study explained the prevalence and types of support sought on social media but did not report on the actual experiences of receiving support (Bridges, Howell & Schmied, 2018), while the other two expressed how support (or lack thereof) influenced their perceptions and duration of breastfeeding (Asiodu et al., 2017; Burns et al., 2010).

Other ethnographic studies have investigated the experiences of breastfeeding mothers in specific contexts such as neonatal units and migrant women breastfeeding in a new country (Flacking & Dykes, 2013; Schmied, Olley, Burns, Duff, Dennis & Dahlen, 2012). A total of 52 mothers, 19 fathers and 102 staff were observed and interviewed in Sweden and England to investigate the experiences of initiating breastfeeding in NICUs (Flacking & Dykes, 2013). The data revealed that the environment was very influential to the infant feeding experience (Flacking & Dykes, 2013). The environment and actual design (level of privacy, amount of foot traffic, presence/absence of door, etc.) of each NICU largely influenced the level of connectedness to their infant (Flacking & Dykes, 2013). A meta-ethnographic study investigating the experiences of migrant women breastfeeding in a new country included 11 studies with 322 mothers of children under the age of 5 years of age were included in the review

(Schmied et al., 2012). Almost all of the studies reported that mothers believed breast milk was best for the infant, that they received conflicting messages about breastfeeding practices, and that the support (and in some cases the lack thereof) influenced their breastfeeding practices (Schmied et al., 2012). Though the women in these studies encountered a unique set of challenges initiating and carrying out breastfeeding, the reports of environment, support and conflicting messages remain consistent across multiple fields of research. As such, it is crucial to consider not only the breastfeeding outcomes, but also the social and personal contexts surrounding breastfeeding mothers.

Breastfeeding is a complex process that has the potential to be both personal and medical in nature. Breastfeeding is often defined in medical terms such as nutritional components and health benefits (Torres, 2014). Furthermore, breast milk is often examined separate from the act of breastfeeding leaving opportunity for the simultaneous medicalization of breast milk and the demedicalization of breastfeeding (Torres, 2014). In this context, the term medicalization refers to processes that are treated in as medical when they are nonmedical in nature (Conrad, 2007) and demedicalization is the opposite, when a process or issue no longer maintains its medical meaning (Conrad, 1992).

When considering the medicalization and demedicalization of breastfeeding it is relevant to consider the women who are breastfeeding and the medical professionals that are providing care for breastfeeding mothers (Torres, 2014). Data from a larger study investigating the roles of International Board-Certified Lactation Consultants (IBCLCs) and doulas in the maternity care system was used to investigate the intricacies of the different roles of IBCLCs (Torres, 2014). The data used from the larger study consisted of 19 International Board-Certified Lactation Consultants (IBCLCs), 11 clients/patients and 9 health care professionals (doctors, midwives and

nurses) and consisted of both observations and interviews (Torres, 2014). The IBCLCs worked to demedicalize breastfeeding though minimizing doubts surrounding the quality and quantity of breast milk, most of these doubts centered around the idea that milk was easily contaminated especially surrounding maternal medications (Torres, 2014). These doubts were significant sources of unnecessary medical interventions because they often led to mothers supplementing and "pumping and dumping" rather than remaining involved in active breastfeeding (Torres, 2014). As a result, these IBCLCs spent considerable time advocating for breastfeeding mothers and trying to prevent unnecessary intervention and interruption to the breastfeeding relationship (Torres, 2014). In addition to their efforts to limit medical interventions, hospital personnel and other doctors interviewed noted that the IBCLCs were viewed as the primary contacts for the medical management of breastfeeding (Torres, 2014) The results from this study suggest that IBCLCs navigate a delicate balance between providing the medical support necessary while simultaneously being careful to not interfere with the relational and nonmedical nature of breastfeeding (Torres, 2014). Breastfeeding is a complex experience and process that requires intentional and appropriate support.

Ethnography and phenomenology have been utilized to study a wide range of breastfeeding topics, but very few studies have explored breastfeeding support groups. Specifically, there are no known ethnographic or phenomenology studies observing a healthcare provider facilitated face-to-face breastfeeding support group. As indicated in this literature review, there is a need to explore and describe the culture, values, practices and experiences within face-to-face healthcare provider led support groups. Utilizing ethnographic observations in partnership with in-depth phenomenology interviews provides an excellent opportunity to address this gap in the literature. This dissertation will provide an in-depth description of the

culture of the group as well as provide insights into the experiences of women receiving support from the peers and medical professionals present in this group.

Breastfeeding support groups are experience-based interventions in which the participants influence the nature of the support sought and provided (Leeming, Marshall & Locke, 2017). Therefore, when studying breastfeeding support groups, it is valuable to consider the context in which the support is being provided and the personal experiences of the women participating in the support group (Leeming et al., 2017). Breastfeeding support intervention is an interactive process in which the needs of the women dictate the support provided by peers and healthcare professionals (Leeming et al., 2017). A merging of phenomenology and ethnography makes visible the nature of the support sought as well as a detailed account of the personal experiences of the women participating in a face-to-face healthcare provider facilitated peer support group. Lastly, the use of symbolic interactionism will allow the substance and efficacy of the group to be determined by the experiences and meanings of the participants themselves.

Chapter 3: Methods

Objectives

The present study provides a detailed multi-method 15-month phenomenological investigation of a face-to-face healthcare provider-led breastfeeding support group. Group meetings were observed and group members (i.e., mothers and healthcare providers) participated in phenomenological interviews followed with member-checks of themes to obtain in-depth accounts of their experiences participating in the support group. The purpose of this study was to gain a better understanding of a US healthcare provider facilitated face-to-face breastfeeding support group and explore the shared experiences of the group members. Currently, limited research exists on face-to-face breastfeeding support groups and a metasynthesis of qualitative data revealed that mothers found it important to receive support from multiple sources (Nelson, 2006). Thus, the group used for this study provided the unique opportunity to obtain insights into a face-to-face support group that provides more than one source of support for women in one place. An understanding of the norms and variations within the support group was observed and reported in conjunction with the self-reported experiences of women through phenomenological interviews. Focusing on the experiences of mothers participating in this specific support group in a state located in the Southern region of the US, with disproportionately low breastfeeding rates, this study provides unique insights into the experiences of women who sought support while navigating the potentially complex and challenging experience of breastfeeding.

This study utilized the philosophical tenants of phenomenology and the theoretical lens of symbolic interactionism to guide the data collection and analysis. Phenomenology and symbolic interactionism were used in conjunction with each other due to the fact that they offer unique

direction for understanding not only the lived experiences of the participants but also the beliefs that influenced their experiences. Phenomenology guided the procedures and analysis of this study. It provided standards for data collection and analysis of the data. The procedures outlined below were followed as outlined by the University of Tennessee Phenomenology Research Group (PRG). The PRG is a multidisciplinary group of students and faculty members. The members of this group range from faculty members with years of experience to students seeking advice and support with their first phenomenology study. The group serves as a sounding board for individuals to receive feedback and confirm themes emerging from the data. This process is thought to provide a higher level of trustworthiness for the analysis process and to help develop expertise in the phenomenology methodologies (Sohn et al., 2017).

The purpose of this study was to provide an in-depth understanding of a face-to-face healthcare facilitated breastfeeding peer support group, which is why the methods selected provided the opportunity to examine both the lived experiences of the participants and the culture of the support group in the words of the participants. The research questions addressed in this study are related to the shared lived experiences of the participants, how the context of the group influenced participants' experiences, and common themes of the group culture and of the participants' experiences.

Methods

Qualitative methods were utilized in an effort to describe the group through the voice and shared experiences of the group members and the group facilitators. Specifically, participant observations and phenomenological interviews were used. These different sources of data allowed for triangulation of the themes as well as a rich description of both the group itself and

the experiences of those participating in the group. The timeline for data collection can be found in Figure 1 (see appendix A for Figure 1).

I spent extended time in the field attending group meetings and collecting ethnographic observations. The first phase of observations was done in an effort to immerse myself in the group as a participant observer. I attended meetings and participated in the group to familiarize myself with the structure and context of the group as well as build trust with the group members and the facilitators. The next phases of observations were conducted in an effort to gain insights into the values, practices, and norms of the group. The phenomenological interviews served as the central data source and were utilized to gain the lived experience of the participants. Each participant participated in a 60-90-minute interview that was followed with a brief member check session at the end of the study. These methods in conjunction with each other provide a multifaceted description of the group examined.

Participants and Context

The participants for this study all attended the same in-person healthcare provider facilitated breastfeeding support group. Prior to data collection, I attended group meetings from the end of May 2019 through the end of August 2019. Attending meetings allowed me to gain access to and get acclimated with the group and the group facilitators. There was a total of 12 participants in the study. The three group facilitators were included as participants since they were present and included in all observations. There were seven additional women who consented to participate in the observations. Of these seven women who consented to the observations, five of those women also participated in an individual interview. There was a total of seven women who participated in the interview, five who participated in both the observations and an interview, and two mothers who participated in the interview but not the observations.

Though these two mothers did not participate in the observations, it is important to note that they were attending the group and met the inclusion criteria of attending a minimum of one meeting per month over a 3-month time period (see Appendix B for participant chart).

Group Context. The group examined in this study was affiliated with a local hospital. The group was free of charge for all women, regardless of where they gave birth. At the beginning of the study, the group met on the first and third Wednesday of every month, but at the start of January 2020 the group began meeting every week until the second week of March 2020 when the group stopped meeting due to COVID-19. The group did not have a designated room in the hospital, therefore the group often met in different rooms. The rooms were subject to change, but the meetings were always held in one of four rooms in the hospital. Women were required to call and tell the hospital they were planning on attending and during that conversation women were given the location of the meeting.

Though the room was subject to change, the group facilitators put great effort into establishing similarities in the environment. Specifically, the facilitators made sure that the rooms were set up so that women could sit in a circle. Sometimes this circle was made with tables and chairs and other times the circle was created with only the chairs. This circle allowed for women to engage in conversation with the women right next to them and the women across from them. Also, the circle allowed for mothers to remove themselves from the group if they were distressed or wanting more privacy. Mothers removed from the circle were able to turn their back to the group, the facilitators sometimes used their body as a shield, or the distressed mothers were able to sit in a different area of the room than the circle. All of the chairs and tables, in every potential meeting room, had wheels. Women were able to easily move as they

pleased. In addition to setting up the physical space in the same way, the group meetings had a predictable flow of operations.

Each time a mother attended the group there was a certain level of consistency in what they could expect to happen. At each meeting, mothers would weigh their infant, feed their infant, and then weigh their infant after the feeding. The number of times a woman would nurse her infant and weigh her infant would vary, but women were welcomed to nurse their infants and weigh them as many times as they pleased during each meeting. The goal of the nursing and weighing was to get a rough estimate of how much breast milk the infants were getting at each feeding. Though these were the expectations of the meetings, facilitators made sure to have a flexible environment for women. Mothers were welcomed to join and leave the meetings as they saw fit and they were welcomed and encouraged to feed their infants however they chose (nursing their infants, pumping breast milk, and using formula).

Recruitment. Participants were recruited from a medium-sized city in Tennessee, where 27.2% of infants are exclusively breastfed through 6 months. All mothers were recruited from within the same healthcare professional facilitated face-to-face breastfeeding peer support group affiliated with a local hospital. The support group was selected based on the willingness of leaders to participate in the study, the structure of the group (healthcare professional facilitated, face-to-face meetings and peer-based support provided), number of meetings held per month (at least two), and potential for a diverse sample because the group was free, connected to a hospital and easily accessible for mothers. Utilizing this specific type of group for the study allowed multiple layers of maternal experiences as well as group practices and values to be observed and described in detail. Furthermore, the multifaceted nature of the group made it possible to

participate in and examine the lived experiences of women receiving multiple sources of breastfeeding support (peer support and healthcare professional support) in one place.

Prior to the second week of March, when the group discontinued meetings due to the COVID-19 pandemic, participants were recruited at the end of the group meetings. Since I was present at all of the meetings, I only recruited women once they had attended a minimum of one meeting per month over a 3-month time period spanning from the end of May 2019 through the first week of March 2020. Once mothers had attended enough meetings, I conducted a brief screening interview to ensure they were 18 years of age or older. After the start of the COVID-19 pandemic shut down group meetings in the second week of March, participants were recruited through snowball sampling. All participants recruited through snowball sampling went through a screening interview to ensure they had attended a minimum of 3 meetings over a 3-month time period, were 18 years of age and older and had an infant they were currently feeding.

All participants signed a consent form for both the observations and the interviews. Before the group stopped meeting in March due to COVID-19, mothers were approached in person and given a verbal explanation of the study. They were then given a written explanation of the purpose of the study, what it means to participate in the study, potential risks, and benefits. Mothers were told that they could discontinue participation of the study at any time. Each mother was given the option to look over the informed consent form then or to take the informed consent form home and return it at the next meeting. Once consent was obtained mothers were asked to fill out a brief demographic form. After the group stopped meeting in March due to COVID-19, mothers were given my contact information from other mothers in the group as well as the group facilitators. Once mothers contacted me, I conducted a brief screening interview to ensure they were 18 years-of-age or older and had attended the group a minimum of one meeting per month

over a 3-month time period. If they met the inclusion criteria, I gave them a brief explanation of my study and the interview process. If they expressed interest in participating, they were given the option of me mailing the demographic and informed consent forms with a return envelope or filling out the forms electronically. All mothers chose to have the forms sent to them electronically. Once I received the informed consent form and the demographic form from the mothers, I contacted them to set up a time to talk.

Characteristics of Sample. All participants completed a demographic survey. The mothers who participated in the group filled out a different demographic form than the group facilitators (see Appendix C for demographic surveys). The mothers from the support group who participated in the study ranged in age from 30 to 40 years of age and all of the participating group attendees were first-time mothers. All mothers indicated that they were breastfeeding their infant in some capacity. All but one mother was currently employed and all, but one mother was married and living with the father of their infant. The mothers in the group had high levels of education and mid to high ranged household income levels with household income levels ranging from $49,000-$51,999 to above $91,000. The majority of women reported a household income of $65,999 and higher (n=7) with four of those mothers reporting a household income of $91,000 and above. All but one mother had received a higher education degree and two mothers had a PhD and four had a master's degree. A summary of key demographic information for the mothers attending the group are presented in Table 1 (see Appendix D for the demographic table).

Though the participants in this study from a largely homogenous socio-economic sample, it is important to note that the demographics these mothers have in common are reflective of the current breastfeeding trends in the US. The 2018 Breastfeeding Report Card revealed that

mothers with only a high school degree were 20% less likely to initiate breastfeeding when compared to mothers with a college degree and mothers living in poverty were 17% less likely to initiate breastfeeding than mothers with higher family income levels (CDC, 2018a). Thus, it is not surprising that the mothers attending a breastfeeding support group would be mothers with higher levels of education and household income levels.

The group facilitators were all International Board-Certified Lactation Consultants (IBCLCs) and Registered Nurses. They ranged from 43-58 years of age, were all women and had been working at the current hospital for a minimum of four years. They each had 20+ years of experience providing support for breastfeeding mothers. All of the group facilitators have children of their own and had personal experiences breastfeeding. Key demographic information about the group facilitators can be found in Table 2 (see appendix E for the demographic table).

Procedures

Prior to data collection, I attended group meetings to familiarize myself with the group as well as build trust with the group members. Women who were interested in participating were given and asked to sign an informed consent form. Once the mothers signed the informed consent form, they were asked to fill out a demographic survey addressing questions related to the mothers age, her education level, parenting classes she attended, questions about her infant's age and sex, infant feeding, marital status, and maternal and paternal occupation status. They were told that they could take the forms home and complete them there or they could complete them at the group meeting. Once mothers signed the informed consent form, they were then included in the participant observations and asked to participate in interviews.

Participant Observations. Prior to attending group meetings, I obtained permission from both the group facilitators and the human resources department of the hospital. I attended

two meetings a month from the end of May 2019 through the end of August 2019. During these meetings, I was able to not only familiarize myself with the group but also, I was able to begin building relationships with the group facilitators and group members. I brought a notebook with me and sat in the circle with the other mothers. I participated in informal conversations with the group whenever addressed and wrote down my thoughts as they arose. In addition to keeping a journal during observations, I had weekly debriefing meetings with my major professor to discuss any issues, questions, or personal biases that arose. The first phase of observations served as a way to learn how to participate in the group without interrupting the flow, reflect on personal reactions to the group meetings, and build a trusting relationship with group members. These observations were vital to gaining access to participants and learning how to become a part of the group.

Ethnographic observations lasted from the beginning of October 2019 through the second week of March 2020. Observations ended in March 2020 due to the discontinuation of group meetings as a result of COVID-19. During observations I situated myself within the group circle, brought my infant and participated in the group practices; having my infant with me allowed me to truly immerse myself within the group. I brought my notebook with me to every meeting and jotted down quick notes. Once the meeting was over, I transferred my observations to a different notebook with more detail and organization.

The observations were all organized in the same way with the attendance number at the top, followed by the description of the environment, and then notes about topics and actions occurring during the meeting. Each observation started with a count of the women at the meeting, denoting how many new and returning mothers were there and how many participants

were present. After I recorded the group attendance numbers, I moved into describing the physical aspects of the room.

The meetings were not in the same room every time. Sometimes the meetings would be in the same location for several meetings in a row and other times the meetings would be in a different room every meeting. Though the meetings moved rooms it was always in one of four rooms. Thus, the physical setup of the room was always recorded in the beginning. In addition to the physical environment of the room, the perceived emotional climate of the room was recorded (calm, casual, high energy, etc.). After the meeting space was described, I would participate in the group like the other mothers and take note of significant observations. During this time, I recorded topics discussed and action taken by both the group members as well as the facilitators. After each meeting, I spent time fleshing out the observation notes. During this time, I added my interpretations and notes about my presence in the group. I recorded my actions and the conversations I engaged in and who I engaged in conversation with.

Phenomenology Interviews. Prior to conducting phenomenological interviews, I did a bracketing interview over zoom with a member of the PRG that I had never met. In this interview, I was asked questions about my experiences with breastfeeding as well as my thoughts, beliefs and opinions about breastfeeding. Once I completed the transcription, I presented the bracketing interview to the PRG. Two members read the interview out loud to the group and feedback was given. The group provided me with valuable feedback about thoughts and feelings I needed to pay attention to within myself during data collection and about how to best interact with participants during interviews. This process allowed me to see where my potential biases were as well as helped me recognize themes within my own experiences and beliefs that I might not have otherwise noticed.

Once the bracketing interview and feedback was completed, I conducted a pilot interview over zoom. After the interview was transcribed, I presented it to the PRG. During this PRG meeting members picked out themes in the participant's response as well as patterns in my interaction with the participant. The group then identified areas for improvement as well as noting strengths in my interviewing skills. Group members gave me advice on how to improve on and uphold the standards of phenomenological interviews. After this meeting was completed, I began conducting interviews with more participants.

A mixture of in-person and snowball recruitment techniques were used to obtain consent from participants for the interviews. Originally, participants were recruited in person after group meetings and snowball methods were used after the start of the COVID-19 shutdown. All of the interviews were conducted after the start of the COVID-19 pandemic, so mothers were given the option to talk over the phone or Zoom. All of my interviews were conducted over the phone or Zoom. Specifically, two interviews were conducted and recorded with Zoom and five were conducted over the phone and the audio was recorded with Zoom. All of the interviews conducted over the phone were done on speakerphone in a private room with my phone near the computer speakers to record the audio file. All audio files were saved on my password-protected computer that only I have access to.

Once the interview was arranged, each participant went through a semi-structured phenomenological interview (see Appendix F for interview questions). At the beginning of each interview, I briefed them on what to expect during the interview and told them that if they felt uncomfortable or didn't want to continue the interview at any point to let me know and I would stop the interview. No mothers indicated that they were uncomfortable or that they wished to discontinue participation in the interview. All mothers were asked about their experiences

feeding their infant, their experiences making infant feeding choices, and about their experiences with the selected support group. More specifically, mothers were asked about why they joined the group and their experiences interacting with both the mothers and group facilitators. Participants were asked clarifying questions and follow-up questions to obtain more detail about their experiences when necessary. At the end of each interview, I asked mothers if they had anything else they wanted to share and if they had any mothers from the group, they could share my contact information with to participate in the study. Once key themes were identified I contacted interview participants and conducted member checks to confirm themes.

Data Analysis

I was the only researcher coding and analyzing the data, but I regularly consulted with my major professors (i.e., dissertation co-chairs) and the PRG. Consulting with my major professors and the PRG provided a more reliable data analysis and thematic development process. One co-chair also attended one of the transcript review sessions hosted by the PRG as well as the final PRG session that focused on confirming the themes of the entire dataset. Data analysis was an ongoing and recursive process. The observations and interviews were analyzed at the same time and helped triangulate the themes emerging in both. Interviews were conducted until saturation was met according to the standards of the PRG. Observations were refined and directed through meetings and preliminary coding. Thus, the analysis process was informed and refined by the data itself.

Coding Observations. Due to the fluid nature of the group, the observations served largely as a way to gain access to and build trust with the group. For example, I always sat in the group with the mother and participated in group practices, such as nursing and weighted feeds. I also built relationships with the mothers and their infants, especially mothers who attended the

group regularly. We were able to remember each other's infants and struggles and check in with each other. I engaged in regular conversations with the mothers one-on-one and in the group setting. Immediately following every meeting, I spent time going over my notes and writing more detailed and organized observations in a different notebook than the one I took notes with during the group meetings. This reflection time served as my most preliminary form of data analysis. It allowed me to organize the observations and take note of what was becoming a significant occurrence at group meetings over time. I was also able to reflect and identify my personal reactions to the group meetings so that I could discuss them later with my major professor at our weekly meetings. These two processes served as the foundation for theme development and helped direct my observations until they ceased due to the COVID-19 shutdown.

After two months (four meetings) of observations, I brought in my notebook to look over with my major professor. During our meeting, we identified reoccurring themes, areas that needed to be fleshed out, and details that needed to be included in future observations. The next phase of observations lasted from the second week of January 2020 through the second week of March 2020 and consisted of a total of six meetings. I continued to reflect after each observation and have weekly debriefing meetings with my major professor.

The second week of March was the last meeting held before the group stopped meeting in response to the COVID-19 pandemic. As a result, I was no longer able to collect observations and began more in-depth rounds of coding. I went back through the observations and looked at all of the significant notes that were highlighted in my journal. I took notes and headings were written in the margins of the observation journal (Elo & Kyngäs, 2008). During this second layer of coding, I was actively conducting the phenomenological interviews with the mothers. All

observations were read through until all aspects of the content were described in the margins (Burnard, 1991; Hsieh & Shannon, 2005). Once the margin notes were complete, I went back through the observations and made a codebook (Cole, 1988; Downes-Wamboldt, 1992). I went over the codebook with my major professor and identified areas that needed more detail. I then went back to the observations to try and identify layers of depth that were missing from the first round of codes.

The interviews served as a guiding lens for identifying depth in the observations that I had previously missed. The interviews helped me identify topics discussed in the meetings that were significant to the mothers. For example, the different styles of holding positions, having conducted the interviews allowed me to recognize the significance the different holding positions had for the mothers in the group. Once I went back through the observations, I reformed the codebook to include more depth and to reflect the significant themes that were discussed in the interviews.

The codes were then grouped into more general headings to reduce the number of categories by combining those that were similar (Burnard, 1991; Downes-Wamboldt, 1992). Each category was named using the language of the participants (Elo & Kyngäs, 2008) and subcategories were created within the larger categories to further organize data that were similar (Dey, 1993; Robson, 1993). The values, beliefs and processes of the group were described and organized through the subcategories and were grounded in the language of the group members. Once the codes were complete, I typed the observations and uploaded them to NVivo to further organize and code the data.

Coding Phenomenological Interviews. Analysis of the phenomenological interviews was ongoing and done according to the procedures of the PRG. After my bracketing interview

was discussed by the PRG, I conducted a pilot interview. This interview was transcribed and presented to the PRG. Two members of the group read through the transcript in an effort to provide feedback on both my interviewing skills and the analysis of the participants' responses. I was also given feedback on my interviewing skills including areas I could improve on and things I did well. After this meeting, I started to conduct the rest of the interviews.

The first phase of coding started with the transcription of the interview. After the interviews were transcribed, I went back and listened to the audio files again. This process was done in an effort to familiarize and further emerge myself with the data. After re-listening to the audio files and rereading the transcripts I began the process of coding and sharing my transcripts with the PRG. Including the pilot interview, four interviews were shared and discussed with the PRG. Each transcript was read out loud by two members, with one member acting as the interviewer and the other as the participant. Throughout the reading of the transcript there were breaks in which the group discussed different words and phrases that seemed significant to understanding the phenomenon (Sohn et al., 2017). Items that seemed significant to describe the experience of participating in this group were discussed amongst the group throughout the reding of the transcripts. Extensive notes were taken on the feedback from the group and were then used to inform my independent coding of all interviews (see Appendix G for PRG procedures figure).

During my independent coding I followed the guidelines and procedures of the PRG (see appendix H for PRG analysis procedures figure). I began coding by taking notes in the margins of what stood out as significant. Once this was complete, I read the transcripts out loud in an effort to further merge myself in the data and in an effort to interact with the data in a new way. The transcripts were analyzed line by line in an effort to capture the words, metaphors and phrases the participant used to describe her experiences (Sohn et al., 2017). There were both

micro and macro aspects of the transcripts recorded (Sohn et al., 2017). That is, both the individual words used by the participant and the phrases used by the participants were identified as meaning units (Sohn et al., 2017). Once this was complete, themes within the transcripts were identified and recorded.

Commonalities between the participants' descriptions of and experiences with the phenomenon were identified as global themes. In order for something to qualify as a global theme, it had to be present in every transcript or at least not contradicted in any transcripts (Sohn et al., 2017). The main purpose was to identify themes that were representative of the collective story told by the women interviewed. The themes were constructed from the words and phrases of the participants and were used to help organize the data further. Once themes were identified, I began organizing the data into different categories within the global themes. These preliminary themes were presented to the PRG for feedback (see appendix I for first these preliminary themes). In this meeting, members provided resources to help better organize and tell the collective story of the mothers interviewed. Though the groupings first brought to the group aren't the ones presented in the findings section, this organization was an important aspect of the analysis process. From these categories, the final story emerged. The original themes presented were an important aspect of the writing process as they provided the foundation for the analysis and writing process. It is important to note that these categories were a vital component to finding the shared lived experience presented below.

Prior to presenting themes to the PRG group, I went back to the mothers I interviewed to confirm the themes. Mothers were asked whether or not they agreed with the themes I had identified throughout the analysis process. These key informant interviews were done over the phone and were brief, no longer than 15 minutes (see Appendix I for key informant interview).

These interviews were not recorded or coded, they were conducted in an effort to enhance the reliability of the themes. Once the themes were confirmed with the mothers, I presented them to the PRG. The group read over the themes and the quotes used to support the themes. They discussed the overall story as well as the individual words used to label each theme and subtheme. These different aspects of the themes were discussed and revised until a consensus was met within the group (Sohn et al., 2017). The themes agreed upon were reflective of the collective story of the women interviewed in an effort to understand the meaning of the phenomenon to those who experienced it.

Establishing Trustworthiness and Data Triangulation

Several methods were used to establish and maintain trustworthiness of the data collection and analysis methods of this study. It is important to establish trustworthiness of the methods and data analysis to ensure the rigor of any qualitative study (Polit & Beck, 2013). Specifically, this study followed the procedures outlined by Thomas and Pollio (2002) in addition to rigorous involvement with the Phenomenological Research Group (PRG) at UTK. This group included both experienced and novice phenomenology researchers from multiple universities across the US. I followed the guidelines of this group prior to data collection through the end of the analysis and writing process. Through the help of this group, in addition to other methods, I addressed the necessary criteria outlined by Guba & Lincoln (1994), which include credibility, dependability, confirmability and transferability. Below I will detail the ways in which I have adhered to these criteria, which also serves as a way to establish the transparency and rigor of the protocols followed in this study (Amankwaa, 2016).

Credibility. Credibility includes prolonged engagement, persistent observation, triangulation, peer-debriefing, negative case analysis and member checks (Lincoln & Guba,

1986). I had lengthy and intensive contact with participants in the field (Lincoln & Guba, 1986). I participated in group meetings from May 2019 through March 2020. I was persistently involved with the group as well as engaged with the mothers during this time. I regularly observed through the methods of participant observation. I had weekly peer debriefing meetings with my faculty advisors and monthly de-briefing meetings with both of my advisors starting in July 2020. In addition to these meetings with my advisors, I had regular involvement with the PRG and engaged in discussions about my project, transcripts and analysis process. The group also served to help me with negative case analysis in the way of ensuring data saturation had been met. That is, I continued to collect data until no new themes emerged from the data as confirmed by the PRG. Lastly, once the findings were complete, I did member-checks with participants to ensure my analysis was representative of their experience with the phenomena investigated.

Dependability and Confirmability. Dependability and confirmability are examined through external personnel auditing the data collection and analysis process (Lincoln & Guba, 1986). The use of the bracketing interview is an important component of the rigorous procedures outline by Thomas and Pollio (2002). I participated in a bracketing interview conducted by an experienced member of the PRG. The interview was analyzed and discussed by the PRG. During this meeting, members of the group helped me identify personal beliefs and feelings that I needed to be aware of during data collection and analysis. To further strengthen this reliability and rigor, I conducted a pilot interview that was analyzed by the group. During this meeting, members identified areas that I needed to improve on and advised me on how to proceed. I took three additional transcripts to the PRG for group analysis. In these meetings, the group coded the interviews line by line. Once I was finished coding, I presented a preliminary round of themes.

The group went through the themes and provided feedback on their accuracy. After the meeting, I incorporated their feedback and generated a new thematic structure. I presented the new themes to the group for discussion again. Once the themes were agreed upon by the group, I did member checks with the mothers to confirm the theses. The PRG provided a constant source of audit throughout the entire study and provided consistent feedback and support.

Transferability. Transferability refers to the ability to provide rich enough data so that someone else might be able to apply the findings elsewhere (Lincoln & Guba, 1986). In an effort to provide a rich description of the participants, the group, and their stories I have provided several narratives and figures. I have provided a detailed demographic chart organized by participant for both the mothers and the group facilitators. Additionally, I conducted participant observations for several months in an effort to provide a detailed description of the group context as well as the norms and values of the group. I also provided a description of each interview participant in order to give context to each mother's personal situation. Lastly, I did a thorough write-up of the shared lived experiences of the mothers participating in the group. I have made great effort to provide in-depth detail about the context of the group, the facilitators, the mothers and their lived experiences.

The purpose of the study was to reveal the shared lived experiences of mothers participating in the support group as well as describe the culture and practices of the group itself. In order to ensure the greatest possibility for in-depth interviews with the mothers, it was important for the mothers to trust me. My extended time participating in and attending group meetings allowed me to develop relationships with the mothers. I was not seen only as a researcher to them, but I was also known as a breastfeeding mother. Having detailed personal

stories from the women was a key component to being able to provide a rich description of this group.

Different types of data were collected for triangulation. Specifically, I collected participant observations, phenomenological interviews and member-check interviews. These sources of data provided a level of accuracy that could not be obtained by a singular method. The observations helped inform the interviews and vice versa. Furthermore, the interviews provided valuable insights for the observations. During the interview's women discussed aspects of the group that were significant to them, which in turn allowed me to identify these occurrences in the field notes as something meaningful to the participants. Without the combined data sources, I might not have been able to recognize the importance of these actions through the observations alone. For example, in the interviews, a few mothers mentioned how important changing their nursing position was for them. In my field notes I have several instances when I observed mothers trying different holds or talking to each other about different holds, but I might not have known the significance of the different nursing positions had I not interviewed the mothers. Using more than one data source allowed me to identify themes that were present across data platforms, which increased the likelihood that these themes were reflective of the group values and the shared lived experience of the participants.

Presenting data at the PRG refined my interview skills as well as aided in the rigor of the analysis process. Relying on a group of multidisciplinary professionals, allowed the data collection and analysis to remain grounded in the experiences of the participants. The PRG meetings also provided me with advice and feedback from researchers that were impartial to my research topic. This constructive feedback helped maximize my understanding and the accuracy of the data. Furthermore, the group was an invaluable source of support as they provided me with

advice for improvement and encouragement throughout data collection and analysis. The PRG helped me obtain a level of consistency that I could not have accomplished on my own.

Researcher Subjectivity and Bracketing

The meetings with my major professors provided continued support for me throughout data collection and analysis. These meetings gave me the opportunity to discuss my personal responses and experiences throughout the study and to identify areas of improvement for data collection. Meeting with my major professors gave me the opportunity to unpack my experiences interacting with the group and the participants. This process helped keep me focused on the experiences of the group rather than my own experiences and responses to the support group.

In addition to regular debriefing meetings, I participated in a bracketing interview in accordance with the PRG. The bracketing interview was rigorous and wildly informative. It gave me the opportunity to fully share my experiences, beliefs and values surrounding breastfeeding. The PRG approach acknowledges that it is impossible for a researcher to completely set aside personal knowledge, expectations and biases about the phenomenon (Sohn et al., 2017). This experience proved to be a valuable outlet for me and brought personal beliefs and expectations to my awareness throughout the study (Sohn et al., 2017). Breastfeeding is something that I not only have strong intellectual beliefs about but also have personal experience with as I was actively breastfeeding my infant during data collection. While being a breastfeeding mother helped serve as a bridge to the participants it also meant I had a unique experience of my own that needed to be shared. The bracketing interview allowed me to share everything I wanted and needed prior to data collection in an attempt to minimize my experiences to lead the interview rather than the participants' (Sohn et al., 2017). Going over this interview with the PRG was a humbling and difficult process for me. It allowed me to view myself from an outsider's

perspective and helped me identify areas I needed to be particularly mindful of throughout the data collection and analysis process.

Reflexivity and Role of the Researcher

This area of research was chosen due to my personal beliefs about the benefits of breastfeeding and the importance of peer support for breastfeeding mothers. I believe that having adequate support is necessary for a successful breastfeeding relationship. Furthermore, I believe that mothers living in the US are not receiving the level of support needed to overcome the challenges they face while breastfeeding. Due to my strong personal beliefs on this topic, it is vital that I am aware of potential bias.

In an effort to account for my potential bias I kept a journal to provide myself an outlet to record my personal beliefs so that my biases were not reflected in the data analysis. In addition to keeping a journal, I wrote memos to myself as ideas emerged during data collection. These memos informed the analysis process and ensured that my ideas and thoughts during data collection were accounted for. As mentioned before, I also participated in regular debriefing meetings with my major professors to explore questions about methods, meanings, and my personal feelings.

During my initial visits to the group, I was pregnant and once official data collection began, I was actively breastfeeding my infant. I believe that being pregnant and being a breastfeeding mother throughout the data collection process helped mothers feel more comfortable with me. Mothers were able to first see me as a peer and another member of the group before they saw me as a researcher, or someone connected to a university. Being a group participant, I was able to build relationships with mothers, which I believe aided in their ability to trust and feel comfortable with me during the interviews. Much like any relationship, trust is

built over time, which is why extended time in the field is so important for participant observations (Musante & DeWalt, 2010). By bringing my infant and participating in group activities, I was able to establish a common goal of breastfeeding with the other mothers. This common goal is important in building reciprocity with the group, which in turn led to the common goal of sharing and learning about the breastfeeding experiences of the women in the group (Musante & DeWalt, 2010).

I also established trust with the participants and my role as a participant by spending 10 months with the group. This time also helped me better identify the norms and values of the group as well as better understand what it means to be a participant in the group. As a participant observer, I must be able to take part in the group activities and actions but also remain removed enough to have awareness of the different aspects of the group. Breastfeeding can be a highly personal experience and since I was first viewed as a breastfeeding mother by participants it allowed us to connect on a level we likely otherwise wouldn't have been able to.

Ethical Considerations

Measures were taken to protect the rights of the participants. During recruitment, potential participants were all provided an informed consent form. This form detailed the nature of the study, what it meant to participate, and the potential risks and benefits associated with the study. Participants were told that they could discontinue participation in the study at any point and prior to conducting interviews I reminded the participants that they could discontinue participation at any point. Anonymity was protected by keeping consent forms with participants' names separate from all other data in a folder in a locked filing cabinet. Furthermore, no identifying information was collected during observations or interviews and all names were omitted from transcripts.

Breastfeeding can be a highly personal and challenging experience for some women. Throughout the observations there were visibly distressed mothers. These mothers were left out of observations and I did not ask them to participate in the study until they had attended more than two meetings without major signs of distress (i.e., crying for extended periods of time during the meetings or purposely removing themselves from the group to have more private conversations with the group facilitators). During the interviews, mothers were asked to discuss their experiences breastfeeding and participating in the group, which had the potential to make mothers uncomfortable. Though there was potential for mothers to feel uncomfortable, it is important to note that none of the mothers expressed any discomfort and there was no evidence to suggest that mothers were uncomfortable with any of the questions asked. All mothers answered every interview question and did so with great detail. Before the interviews began, I reminded mothers they could discontinue participation in the study at any point and told them that if they felt uncomfortable or preferred not to answer any questions to let me know.

All data was stored in secure locations in an effort to minimize the risk of participant identification. All consent forms and demographic surveys were put in separate folders in a locked filing cabinet. Each audio file and transcript were saved in different folders on a password-protected computer that only I have access to. Each transcript was labeled and saved as "Participant ___" and filled in with a number. The audio files were saved and labeled according to the date in which the interview was conducted. These measures were taken to help ensure the comfort and protection of the participants. All participants who signed the informed consent forms remained active in the study until data collection was complete. Two mothers chose not to participate in the interview but remained in the study until the observations were complete.

Chapter 4: Findings

Introduction

The observations and stories shared by the participants provided a rich description of the group context as well as the shared lived experiences of women participating in the same breastfeeding support group. The context of the group and the shared lived experiences of mothers participating in the group are discussed in the findings. Due to the nature of the research questions as well as the data collection and analysis methods, an understanding of the context enriches the shared story of the participants. That is, it is important to understand where the collective story takes place to paint a more complete picture of what it means to participate in the support group examined in this study. The context of the group is described first, followed by the global themes that emerged from the shared experiences of the mothers and a discussion about the relationship between the context and identified themes.

Group Context

Group meetings were always held on the same day of the week, at the same time and at the same hospital. At the beginning of the study the group met every first and third week of the month, but starting January 2020, the group began to meet every week. The meetings had several consistent components: chairs and tables were on wheels and easily moved, chairs and/or tables were set up in a circle, there was an infant scale in the corner of the room slightly removed from the group, women signed a sign-in sheet, only women were allowed in the meetings and the same group facilitators were present at each meeting. The rooms are detailed in figure 5 (see Appendix J for Figure 5).

Group Environment

The group was organized and monitored by the group facilitators. There were three facilitators who ran the group together and all three were present at the majority of the meetings. The facilitators individually checked in with each mother at every meeting. The needs of the mother largely dictated the ways in which the facilitators interacted with the individual mothers and the group. That is, each woman had the opportunity to have a one-on-one conversation with each of the group facilitators throughout the meeting. Some women wanted and/or needed more private assistance and the facilitators would respond accordingly. If a mother was in need of privacy, the facilitators and the mother would remove themselves from the group and work quietly together. If all of the mother's had their concerns addressed, the facilitators would sit with the group and engage in conversation with the mothers. For example, during one meeting in January 2020, one of the facilitators posed a question to the entire group. She asked the mothers what advice they had for new mothers. As a result, mothers began an open discussion about their advice and experiences in the early postpartum period. Thus, the facilitators guided the group but allowed the needs and responses of the mothers dictate the direction of the meeting.

The group was generally very casual and fluid. Women were welcomed to come and leave the group meeting as it best fit their schedule. There was an official start and finish time, but no one was obligated to stay the duration of the meeting time. Women often showed up 30 minutes after the group started and some would even show up 30 minutes before the meeting ended. On January 29th, 2020 a mother only attended the last 30 minutes of the meeting. While this wasn't terribly common, mothers regularly left meetings before the designated "end time". Due to the relaxed environment of the group, this late entrance or early exit didn't disturb the

group. Mothers were able to leave the group when they had finished feeding their infant or had their concerns addressed.

All women were welcomed the same, regardless of when they arrived. When they walked in each woman was greeted by one of the facilitators and was told to come in and encouraged mothers to sit in the group with the other women. The facilitators had one-on-one check ins with every mom at each meet. They would walk around the room and quietly ask the mother how she was doing or what brought her to the group. The majority of time women joined the group but there were times mothers would separate themselves from the group and receive private assistance from the group facilitators. For example, on November 20th there was a mother who cried the majority of the meeting. The fieldnotes from that day state that a lactation consultant was with her the entire meeting and at times she even had two facilitators helping her.

The mothers present at group meetings changed from one meeting to the next; that is, the women present at group meetings weren't the same each time. The first meeting in November had 10 total mothers with 5 of them returning mothers, while the second meeting in November had 5 total mothers with 1 a returning mother. The first meeting in December had 7 total mothers with 4 returning mothers (2 of which were participants) and the second meeting in December had 7 total mothers with 5 returning mothers (2 of which were participants). Though all of these meetings had returning mothers, that doesn't mean that they were the same returning mothers. That is, group attendance wasn't consistent or predictable. This fluid nature of the group did lead to some variation in the level of interactions and the energy of the room from one meeting to the next.

The energy in the room appeared to be more dependent on the women present at the group meeting rather than the room itself. Group attendance was constantly changing; sometimes

there were several returning mothers and other times there were no returning mothers. Additionally, the number of women in attendance was constantly changing. Sometimes there would be as few as 4 mothers or as many as 10. Therefore, the group environment varied with the group participants themselves. For example, on February 5th, 2020 there was a meeting in room 2 that was very loud and high energy. There were six retuning mothers at this meeting and 2 new mothers. The high number of returning mothers appeared to increase the level of interactions mothers had with each other. In the fieldnotes the environment was described as "loud" and "hard to hear over all the socialization". This meeting had the highest number of returning mothers at any meeting I attended and also had the liveliest environment of any meeting I attended. That is, the environment was noisy and high energy, there was a lot of laughing and talking as if it were a group of friends hanging out a social gathering. Thus, it would appear that the energy of the meetings was dictated more by the women present at the meeting rather than the room itself.

Body language and proximity was used a lot to determine the comfort level of the women at the group. As previously mentioned, some mothers would separate themselves from the group and spent a lot of time crying. When there were situations like these, the group facilitators were very intentional to speak quietly and privately with these mothers. For example, on December 18th, 2019, one mother attended the group and was far enough removed from the group no one was able to talk with her but the consultants. She cried the entire meeting, was never alone during the meeting and left the meeting early. This mother demonstrated the impact proximity to the group had on the level of privacy they received. The facilitators used their body position to guard this mother from the group as well. That is, the facilitator positioned her body so that the crying mother was shielded from the other's in the room. The facilitators appeared to be very

intentional in these situations to protect the comfort and privacy of these mothers, and they were very intentional about spending as much time as necessary with the mothers. For example, there were several times a group facilitator would spend the entire meeting with one mother assisting them. This is evident by the fact that a facilitator would regularly spend the entire meeting with a mother who was crying or distressed.

Mothers and lactation consultants engaged in both casual and more formal conversations. The conversations ranged from general storytelling, advice on different aspects of parenting (clothing, sleeping tricks, pacifies, teething, bottles, etc.), and discussions about families. For example, there was one meeting in February in which only three mothers attended. There were also three facilitators and after about an hour, the facilitators sat in the circle with the mothers. Since all of the facilitators breastfed their infants, we all discussed our experiences breastfeeding in public, our family's reactions to breastfeeding and introducing solid foods. Everyone sat in the group as equals and shared their stories. It appeared that the facilitators only engaged in large group conversations like this after they had the chance to check in with each mother individually.

More formal conversations included the facilitators showing mothers different nursing positions as well as new techniques for latching. Additionally, facilitators would assess latches and provide recommendations for seeking help outside the group. For example, the facilitators often referred mothers to professionals that could assess whether or not the infant had lip and/or tongue ties. The facilitators also asked mothers to share their experiences with each other. For example, on December 4th, 2019, a facilitator asked a returning mother to share her experiences doing physical therapy with a returning mother. The returning mother told the new mother what she could expect if she went to the physical therapist and told her about how the physical therapy influenced the breastfeeding relationship. Thus, mothers and facilitators engaged in

conversations as dictated by the environment created by the women present at the meeting. That is, the needs of the mothers attending the meeting that day determined how the individuals at the meeting interacted with each other.

Not all mothers participated in conversations with mothers every time, it appeared to be dependent on mothers' comfort levels with the group. For example, some mothers would remove themselves from the group, or position themselves with their back to the mother next to them. The comfort level was largely determined by body positioning and willingness to participate in conversations. In the interview, one mother mentioned that she tried to engage in conversation with a mother next to her and the other mother made it clear to her that she didn't want to talk. There were times the facilitators would initiate conversations between mothers they knew to have similar issues or might have helpful insights for each other. For example, one meeting a facilitator encouraged a retuning mother to share her experiences with a new mother about getting her infants tongue and lip ties cut and the physical therapy that followed. This type of facilitation helped the mothers make connections and to allow mothers to get both peer and professional support from the group.

Meeting Structure.

There was a general structure to the group meetings, but overall women were welcomed and encouraged to engage with the group according to their comfort level. In general, mothers entered the room and were greeted by the group facilitators. Once mothers were greeted, they were invited to sit down and get settled in the group. After mothers were settled, they weighed their infant prior to nursing and/or feeding them. Mothers then nursed/fed their infant and weighed their infant after to get a rough estimate of how much milk the infant got. The weighing and feeding of the infants continued until the infants were finished eating. When mothers were

finished feeding their infants, they were free to leave (for a figure of group events see Appendix K).

The meetings began as mothers entered the room. Though there was a general timeframe for the meetings, the duration (including start and finish) was dictated by the mothers. That is, the meetings didn't start until mothers entered the room and the meetings ended once all of the mothers left the room. Each mother was greeted by the group facilitators as they entered the room. If the facilitators knew the mother, they typically greeted the mother and/or infant by name. This idea was echoed by mothers in their interviews as they discussed that the facilitators remembered them each subsequent meeting and checked back in on the concerns and issues discussed at the previous meeting. If it was a mothers first time attending the group, the facilitators would greet them, invite the mother to sit down and immediately go to the mother and check in with them. As the facilitators checked in with mothers, they were able to discuss the structure of the group and what brought them to the group. Thus, each new mother was formally and informally greeted and welcomed to the group. Returning mothers were greeted and then would typically go through the motions of the meeting without specific prompts from the facilitators. The facilitators provided a loose structure for the meetings but allowed mothers to navigate the meetings as they saw best fit.

Once mothers had been greeted mothers began the process of weighing and feeding their infants. Each mother did this at her own pace and in her own way. For example, some mothers entered the room and went directly to the scales, other infants were asleep, which required mothers to wait for them to wake up and other mothers simply socialized prior to beginning the weighing and feeding process. Though the pace differed from one mother to the next, every mother weighed her infant prior to and after feeding their infant. The objective was to attempt to

figure out roughly how much milk the infant was getting per nursing session. Thus, mothers would regularly nurse on one side, weigh, nurse the other side, weigh and continue this pattern until the infant had enough food. Once the infants had enough food mothers would either leave the meeting or remain and continue socializing with the other mothers and allowing infants to interact with each other as well. For example, on January 15th, 2020, three mothers placed their infants next to each other on mats in the center of the circle and watched the infants touch and play with each other. One infant grabbed another infant's hand and put it in his mouth while another infant tried to roll over. Though the infants weren't all interacting with each other their close proximity provided a shift in environment for the infants as well as the mothers. During this time the mothers watched their infants and engaged in more interactions with each other as they analyzed their infants' actions.

There was a general expectation that mothers would enter the group, feed their infants, weigh their infants and have a chance to check in with the group facilitators. Though this was the general structure of the group, mothers were not required to do anything but show up. For example, there were several times in which mothers seemed to be distressed (frequent crying and separation from the group) and they did not always weigh their infant like the rest of the mothers. Other times there were mothers who brought bottles to feed their infants, which obviously didn't require the scale to get an estimate of the amount of food the infant received. The general flow gave the meetings a sense of organization, but it was not required for mothers to follow this format. Furthermore, it was not mandatory for mothers to breastfeed their infants. Women fed their infants in many ways at group meetings, there was exclusive breastfeeding, complementary foods, bottle feeding both breast milk and formula.

Group Values and Practices

The values of the group were made evident through the repeated and protected actions of the members and the facilitators within the group. Everyone at this group had a certain level of appreciation for breastfeeding. This was demonstrated by the fact that the mothers showed up to a group for breastfeeding support as well as the fact that every single mother present at the group actively tried to breastfeed at some point during the meetings. The mothers talked about their breastfeeding struggles and experiences with the other mothers and the group facilitators. Breastfeeding was important to both the mothers and the facilitators. That is, the facilitators valued breastfeeding enough to dedicate their lives to helping women with their breastfeeding journey. The mothers in this group valued breastfeeding enough to continue trying to breastfeed despite encountering challenges. Rather than giving up, each of these mothers intentionally sought the support of the group so they could continue feeding their infant breast milk in some capacity.

The value of breastfeeding was evident by the mere presence of these mothers at the support group, but this importance was further echoed in the interviews. Mothers made comments about breast milk having benefits for the mother and the infant. That they wanted to breastfeed for as long as possible and give their infant as much breast milk as they could. Mothers also displayed their dedication to breastfeeding through their willingness to endure challenges and seek support to help them have a successful breastfeeding relationship. In addition to valuing breastfeeding, there was a general appreciation and respect for the mother. That is, it was clear that the mothers valued the privacy and vulnerability of the mothers in the group.

This dedication to the mother was made clear by the interactions and actions between the mothers and facilitators at the group. Mothers and facilitators were sensitive to the needs of the other mother in the room; if someone needed more privacy then the facilitators and other mothers accommodated this need. That is, no one encroached on the personal space of mothers who removed themselves from the group or who were crying throughout the meeting. there were times when the facilitator would call another mother or facilitator over to provide additional support for a distressed mother, but there was a clear respect and value for the privacy of the mothers in the group. another way this was made evident was the positioning of the facilitators body. For example, if a mother was crying or uncomfortable the facilitators would use their body to shield the mother from the rest of the group and they would talk softly. Mothers also mentioned this in the interviews. They stated that if they wanted to discuss something more private with the facilitators they would move off to the side. Mothers also noted that they could always tell if a mother was uncomfortable or didn't want to talk because they would be slightly removed from the group. Thus, it would appear that there was an unspoken rule to respect the boundaries of the women around you. The group was very considerate of the vulnerability of the other mothers in the group.

The group facilitators regularly provided physical assistance for the mothers. They physically moved the position of the infant or used their fingers to assess infant's latch. This hands-on style of support was a significant component of the group. For example, the facilitators would regularly show mothers different positions to hold their infant while nursing. One mother had an issue with and over-supply of milk and a quick let down. The facilitators recommended that the mother lean back some to help slow the milk flow down. The importance of these types of adjustments were evident in the interviews. Mothers regularly mentioned how valuable the

hands-on assistance was and what an impact changing positions had on their breastfeeding relationship. Since breastfeeding is both an emotional and physical experience, it appeared to be important that mothers received assistance for both of these aspects.

The group also stressed the importance of peer support. The facilitators were very intentional about encouraging mothers to interact with each other. For example, facilitators asked mothers to share their experiences or demonstrate different techniques with other mothers. That is, if the facilitators connected mothers who had similar issues or experiences. On November 6th, 2019, the facilitators asked a mother to demonstrate "the guppie" holding position so that another mother in the group could try this position. The facilitator could have easily positioned the infant into "the guppie" position, but she chose to ask another mother to demonstrate the position. This action shows the intention the facilitators put into encouraging peer interactions between the mothers.

The facilitators also made this priority explicit to returning mothers. They encouraged mothers to continue attending the group and always remembered returning mothers. On December 18th, 2019, the facilitators told a group of returning mothers how important it was for them to continue attending the group. She urged them by telling them it is important for the newer moms to see that there is hope and what they have to look forward to. She also explained that their intention in starting the group was for there to be support from returning mothers rather than having every mother be a one-time-only visit. The actions and communication between and with the mothers displayed a clear emphasis on peer support. The facilitators intentionally encouraged interactions between mothers and expressed the importance of returning to the group.

The support group clearly valued new mothers and their breastfeeding journey. There was an emphasis on respect of mother's boundaries and vulnerability. The facilitators set the expectations for the group through their actions. They demonstrated a sensitivity to the mothers' needs and comfort levels and allowed that to guide their interactions. As a result, the mothers followed this example and treated each other's boundaries with respect. The women present at this group had a shared appreciation for the complexities of breastfeeding. They were united through their struggles and the facilitators aimed to provide women with the support needed to improve their breastfeeding relationships. The emphasis on breastfeeding provided a space for mothers to share their experiences and provide a source of validation for each other. These values and themes are discussed in the story of shared metamorphosis in the section below.

Themes of Group Participants

The participant-observations combined with the individual interview data provided an in-depth examination of the lived experience of women who attended the same face-to-face healthcare facilitated breastfeeding support group. In the section below, there is a detailed description of each mother who participated in the interviews and an analysis of the shared lived experience of these mothers.

Contextual Description of Mothers

A brief description and analysis of the seven individual interviews are provided in this section with the use of pseudonyms. Maternal demographics such as the age, income level and education status of each mother as well as other contextual factors such as details about the mother, infant, and family that provide important background information to better understand each mother's perspective. Thus, the reporting of the findings will follow the analysis process; results are first discussed at the individual level and then at the global level to provide insight

and understanding of the essence of the shared lived experience of these mothers. The findings below were generated with a combination of the data from the demographic surveys, the observations and the interviews themselves. As a result, some of the participants provided a richer contextual description than others.

Participant 1: Rachel. Rachel is a 35-year-old first time mother of a male infant, Oliver. She and Oliver's father are married and living together. Rachel has her master's degree and both her and her husband work and have a combined income above $91,000. Rachel went to a hypnobirthing class and a breastfeeding class during pregnancy. Rachel delivered Oliver post-term via c-section. Oliver had to spend time in the NICU due to breathing issues immediately following birth. As a result, Oliver received a combination of formula and pumped breast milk during his stay in the NICU.

Rachel felt that the breastfeeding experience was intuitive. She spoke a lot about her natural instincts and the comfort she found in her son Oliver. Rachel was introduced to the support group by her friend, Veda, from the hypnobirthing class she attended. Rachel initially went to the group seeking help from the lactation consultants and to meet other moms for social support. Rachel had an over-supply of breast milk, as a result Oliver was unable to manage the amount of milk he was getting and often was fussy. Rachel sought help from other medical professionals with no success, but the group facilitators were able to give her the answers and support she was seeking.

Overall, Rachel had a positive breastfeeding experience and enjoyed being part of the support group. She expressed that the group provided her with medical/professional support as well as social connection that was lacking prior to joining the group. She expressed that social support was very important for her since she was from Germany and was unsure about cultural

norms surrounding breastfeeding in the US. Rachel came to the group with a friend from her birthing class and made two additional friends in the group that she continued to stay in contact with after she stopped attending the group.

Participant 2: Carly. Carly is a 32-year-old mother of an infant female, Ella. She is married to and lives with Ella's dad. Carly has her undergraduate degree and she and her husband both work and have a combined income between $78,000 and $90,000. She attended a birthing class and had a medication-free home birth. Ella was born premature at 37 weeks and was exclusively breastfed until she began eating complementary food.

Carly was a highly motivated mother who sought support and information from several sources. She mentioned receiving support from her midwifes, two different lactation consultants, peers who were mothers and social-media groups. She also enjoyed doing research on her own. Carly was persistent in her efforts to seek help until she found solutions. For example, Carly had the following difficulties in the early stages of breastfeeding: 1) she had mastitis twice in the first two weeks postpartum, 2) she had an over-supply of milk, and 3) Ella had a tongue tie which made it difficult for her to latch and handle the milk flow. Carly was able to overcome these early challenges and described breastfeeding as an overall positive experience.

Carly enjoyed the group because of the support she received from the facilitators and the other mothers. She expressed the importance of connecting with women who shared similar lived experiences. She was able to learn more about slowing down her milk flow and infant positioning from the group. Carly noted the significance of leaving the house with her infant to attend the group. The group was a safe space for her to seek the support and obtain the important information. Carly spoke several times about the instant connection she felt with the other mothers. She was able to relate to the other mothers without having to know information about

them because of their shared struggle and experience breastfeeding and caring for newborn children. Carly had a positive experience with the group and stated that it was an important resource for her. She wished more women knew about the groups as resources available to them.

Participant 3: Veda. Veda is a 38-year-old first time mother of a male infant, Brad. She is married to and living with Brad's father. She has her master's degree and her and her husband are both working for a combined income between $65,000 and $77,999. She took a birthing and a parenting class during her pregnancy. Brad was born premature at 37 weeks with a non-medicated birth. He was fed a combination of breast milk and formula until he was given complementary foods. Veda has a close relationship with her parents and has openly discussed breastfeeding with her mother. Veda's mom breastfed her for 15 months and stated that breastfeeding was one of her mother's most enjoyable experiences. As a result, it was important to Veda that Brad received as much breast milk as possible. She also reported that a friend donated milk for Brad.

Veda joined the support group because of she had breastmilk supply issues and wanted answers to her questions. Her primary concern ensuring Brad was getting enough milk. She came to the group seeking help from the group facilitators. Veda talked about how stressful it was for her and her husband to not see how much milk Brad was getting while nursing. The inability to not see the actual amount of breastmilk consumed by her infant "played a psychological trick." She expressed that this "trick" made her think she did not have enough milk. It was important to Veda that she took cues from Brad rather than having him on a strict feeding schedule. Though it was important to Veda to take cues, it appears that having to make persistent in-the-moment decisions was stressful for her. The support group validated her feelings and provided her with unconditional support. She had friends of who were not supportive and as a result, she separated

herself from a portion of her other friends because they did not understand why breastfeeding was so important to her.

Veda had a lot of anxiety and stress surrounding her breastfeeding experience. Determination was demonstrated in her persistent efforts to continue breastfeeding despite the challenges. There was an extended period of time in which Brad refused to nurse. She began pumping so much that she "literally carried the pump around like a purse." Veda noted that she pumped so much that she felt like she had an addiction to the pump. She further noted that she did not enjoy pumping, but it gave her a sense of both physical (expressing her milk) and emotional (being able to give Brad her milk) relief. Brad's refusal to breastfeed felt hurtful and like a rejection. Overall, she stated that breastfeeding was a positive experience and the group provided her with a source of support and validation that she otherwise lacked.

Participant 4: Caitlin. Caitlin is a 32-year-old first-time mother of a female infant, Lydia. She is married to and living with Lydia's dad. Caitlin has her master's degree and she and her husband both work for a combined income above $91,000. She attended a birthing class, a breastfeeding class and a parenting class. Lydia was born post-term at 41.5 weeks and was exclusively breastfed. Lydia had an aggressive jaundice-like condition at birth. As a result, they encouraged her to supplement with formula, but Lydia didn't want to take the bottle. Lydia's refusal of the bottle resulted in Caitlin feeling pressure to figure out how to get Lydia latched and breastfeeding.

Caitlin had a salient meaningful experience with one of the group facilitators, Sarah, in the hospital. She illustrated how helpful Sarah was to her during a time of, what she considered, craziness. Caitlin explained that Sarah slowed down time for her and that it was very meaningful to Caitlin that Sarah was willing to spend as much time with her as she needed. Caitlin's

confidence continued to grow as she interacted with Sarah in the hospital. Once she left the hospital, she was beginning to struggle with Lydia spitting up and her refusing to take a bottle. She did not have any mom friends in the area and was unsure who to turn to. She even had friends dismiss her concerns. She was losing her confidence in breastfeeding and needed additional help. Sarah mentioned the group to her in the hospital, so she decided to join because of the success she experienced with Sara while in the hospital.

Caitlin had positive experiences with both the group facilitators and the other mothers at the group. The group provided her with a sense of stability and helped ease her anxiety. She believed the group facilitators took her concerns seriously and the other mothers also provided a source of support. She stated that she was able to get answers to her questions and build her confidence in her abilities to feed and care for Lydia. Attending the group helped Caitlin receive validation that she was doing the right thing and that she was doing a good job. She didn't know any of the other mothers before attending the group but stated that the group provided her with a source of connection because they understood what she was going through. The group was important to Caitlin. Prior to the group she felt isolated. The group provided her with a therapeutic experience, helped her navigate the challenges she was facing, and allowed her to feel connected to other mothers.

Participant 5: Kaley. Kaley is a 32-year-old British woman and a first-time mother of a male infant, Joe. She is not married to or living with Joe's father. Throughout the course of the study Kaley moved out of the house with Joe's father. She has her doctoral degree and she and Joe's father both work. She indicated that the household income was above $91,000. Kaley went to a birthing class and a breastfeeding class during her pregnancy. Joe was full-term and

jaundiced when he was born. Joe had trouble getting enough food and as a result, he was given a combination of formula and breastmilk in the hospital.

Kaley mentioned that she put a lot of pressure on herself with regards to breastfeeding and caring for Joe. She expressed that she did not view Joe as a shared responsibility with her partner and other family members, but rather she felt like everything depended on her. Though she did not view Joe as a shared responsibility, she did mention turning to family members for support. She contacted her brother, her mother and her sister-in-law for advice and support in different areas. She had a difficult time when people said "he's starving" in reference to Joe. She mentioned that some of her friends and her mother would off-handedly make this comment when holding Joe. She knew that this was a common phrase, but during the early stages of breastfeeding it seemed more weighted and serious. Kaley's mom and sister-in-law both breastfed. She mentioned that her mom was very supportive of breastfeeding and that another feeding option was never discussed.

Kaley joined the group because she was having issues breastfeeding and thought it would be a useful social experience for her. She spent a lot of time discussing what she observed going on in the group with other people. She would make a statement about the group and then support it with an example from something she witnessed in the group, not from her personal experience. The social aspect and opportunity to form relationships with the other mothers was an important aspect of the group for Kaley. She was very intentional about reaching out for support and utilizing the resources available to her. She was a part of a different mother's group but stated that the breastfeeding support group was different because she could open up about the complex aspects of breastfeeding. She also noted how much she appreciated the group facilitators providing multiple options for solutions as well as references for outside resources. Overall,

Kaley had a positive breastfeeding experience and believes that the group made a difference in her breastfeeding journey.

Participant 6: Lauren. Lauren is a 40-year-old first time mother of a female infant, Dana. She is married to and living with Dana's father. She has her master's degree and she and her husband both work for a combined income between $36,000 and $48,999. Lauren attended a birthing class and a parenting class during pregnancy. Dana was post-term being born at 42 weeks. Lauren had difficulties breastfeeding in the hospital and she worried Dana was never satisfied. She mentioned that Dana was persistently fussy, had issues gaining weight, spit-up a lot and "injured" Lauren's skin when she nursed. As a result, she gave Dana both breast milk and formula until Dana started eating complementary foods.

Lauren started attending the support group due to issues with milk supply and discomfort during feedings. Dana had issues with spitting up the milk and/or formula she was fed. As a result, Lauren started eliminating certain foods from her diet. Once she removed these foods and started using a particular formula brand, she was able to notice a reduction in Dana's spit-up. The opportunity to make social connections with other breastfeeding mothers was an important component of the group for Lauren. She found great encouragement and comfort from the support she received from the group. Lauren expressed that she was navigating a "brand new universe" and being able to see other mothers with infants of different ages encouraged her throughout her time attending the support group.

Participant 7: Lisa. Lisa is a 33-year-old first time mother of a female infant, Wesley. Lisa is married to and living with Wesley's father. She has a doctorate degree and her and her husband are both work with a combined household income above $91,000. She attended a

birthing, breastfeeding and parenting class during pregnancy. Wesley was a full-term infant and was exclusively breastfed until she started eating complementary foods.

Lisa had issues with milk supply immediately following Wesley's birth. Her mother was a lactation nurse and was able to provide a lot of support, but Lisa thought she needed some help outside of her mother. As a result, Sarah came to Lisa's house and helped her explore some solutions for her issues. Lisa had a really positive experience with Sarah and ended up attending the group later on. She had questions she wanted answers to and decided she would attend the group. Lisa noted several times how much the group shocked her. She was shocked to see so many women breastfeeding together and to see how comfortable everyone was. Lisa noted how helpful the group facilitators were in answering her questions and that they provided her with a source of support she was lacking. She had great support in her mother, but she was able to receive the support in a different way from the group facilitators and the other mothers in the group. She stated how much she enjoyed being able to see infants at different stages of the journey and to know that she wasn't the only one struggling.

A Breastfeeding Metamorphosis Among Mothers Attending the Same Support Group

In this section, the interview data was analyzed to answer the following research questions: 1) what are the lived experiences of the women participating a breastfeeding support group, 2) how does the group influence their lived experiences, and 3) what were the common experiences of these women? The shared themes remained consistent between the mothers and depict the collective lived experiences of mothers attending the same breastfeeding support group and uncover the salient findings to capture the essence of the collective experience. The findings presented below tells the story of a shared transformation (see Appendix L for illustration of collective metamorphosis).

Butterfly metamorphosis depicts the process by which larva transform into an adult (butterfly). A butterfly's transformation occurs within the cocoon and when it emerges, it is in a new form. The story that follows is one of a collective metamorphosis of first-time mothers who attended the same breastfeeding support group. It starts in a state of despair, a time when mothers felt true anguish over their level of uncertainty surrounding breastfeeding and caring for their newborn infant. During this stage of distress, mothers found themselves in a situation they did not know how to navigate on their own. They were in a position they knew they could not remain in, so they sought the help of the support group. The mothers began their transformation in this group, which served as a sort of cocoon. In this cocoon, mothers were not alone. They were in a safe space that protected them and fostered consistent change over time. That is, the group inspired a transformation in the mother's breastfeeding journey. Thus, mothers went through a metamorphosis in which they started in a condition they knew they could not remain and moved to a state of confidence and connection. In addition to experiencing personal change, the group itself experienced a transformation from strangers to family. The connections and relationships formed in this group provided mothers with a network of support they were otherwise lacking.

This story of transformation is organized chronologically as a mother would have experienced it. In the first phase, determination despite uncertainty, we walk with the mothers through their uncertainty and resulting anxiety and fear. This phase provides insight into the context which led these mothers to seek help outside their immediate resources. The second phase includes the entrance into the metaphorical cocoon (the group), which provided mothers with the safety needed to protect them as they transformed from mothers struggling in uncertainty to mothers with confidence. This phase is broken into the elements of the

metaphorical cocoon including, solutions for the grappling mother, the transition from facilitator to pseudo-family and comradery in the collective grapple. The context of the group, from the perspective of these mothers, is important to capture as it provides insight into the aspects of the group that were significant to the transformative process. Mothers' confidence began to grow as they found solutions to their problems and answers to their questions. Thus, the solutions signified the initiation of the metamorphosis process for these mothers. Additionally, the comradery found in the shared struggles between these mothers were contributing factors to the changes these mothers experienced. Lastly, the transformation from uncertainty to confidence is discussed in phase three.

Phase 1: Determination Despite Uncertainty

Before joining the group, these mothers were in a state of anguish over their level of uncertainty and their unmet breastfeeding expectations. It appears that mothers went into the breastfeeding relationship with anticipation about what the experience would be like based off their prior knowledge and stories from other mothers:

> And then my mom breastfed me for 15 months and my brother for 15 months. And I always knew that because she talked about it a lot. She talked about it being one of her favorite things that she did. And it was bonding and nurturing. And she loved everything about it. She did not have any breastfeeding struggles either. So, she is a very fond memory of it. And so, growing up hearing that and then again, the nutritional aspects. (Veda)

Veda's passage shows the significance of her mother's breastfeeding experience. According to Veda's mother, breastfeeding was one of the greatest aspects of being a mother. As a result, Veda had the idea that breastfeeding would be something that she would enjoy and that would

come with ease for her. While the experience of her mother was an important aspect of her breastfeeding decisions, this passage reveals how expectations for breastfeeding begin forming as some of these mothers were little girls. Veda communicates the complex nature of dealing with breastfeeding expectations, it isn't simply a physical matter. Breastfeeding has the ability to impact mothers on a physical and psychological level.

> So maybe if I had taken like a breastfeeding class or just knew like a little bit going into it how hard breastfeeding would be, maybe it wouldn't be the biggest obstacle that we encountered because I would have been at least prepared for it to be hard. Whereas the notion that I got before ummm before having her… it was just like, you know, breastfeeding is something that's natural. And you like pop 'em on the boob and like, that's that's it. That was not my experience. (Carly)

This passage from Carly demonstrates that she was having experiences that contradicted her expectations. She critiques a common discourse about breastfeeding as "natural" and something that does not take much skill or knowledge. She challenges this idea by noting how difficult breastfeeding is and how understanding the difficulty could have helped her feel more prepared. Thus, the expectations and prior knowledge were different in theory than it was for these women in practice.

> In the breastfeeding class you get all this paperwork, and they do all the theoretical stuff with you. But when the baby's there, it's it's so different. Yeah. So that was kind of a little bit of a rough start. (Rachel)

In this excerpt, Rachel describes the shift from theoretical information obtained during pregnancy to the actual lived experience of breastfeeding, noting that it was a "rough start". Rachel's experience further demonstrates the complexities of breastfeeding. The fact that

breastfeeding is different in theory than in practice suggests that theory does not adequately prepare mothers for the act of breastfeeding. Mothers, regardless of their prior theoretical and anecdotal knowledge, felt unprepared and uncertain about the applied practice of breastfeeding.

These mothers' breastfeeding experience were different from what they expected, which led them to feel a certain level of uncertainty in their ability to feed their child. This doubt led mothers to spiral into deep states of anxiety and pressure related to whether or not they were feeding their infant enough, which ultimately led to feelings of insecurity for these mothers.

> And there are there are many times that I handed my husband the baby and said, okay, I'm done. Like, give her a bottle. I don't care. But eventually I would come back around because I knew that if I kept going and if it got to a place that it was good, that would be more convenient. (Carly)

Carly went on to say…

> I probably was just like the most frustrated person in the whole world. I mean, and those were the first few weeks, probably the most like hormonal changes that you're going through as a new mom. So, it just it's exacerbating everything. And as a new mom or any mom, probably that that doesn't feel like they can successfully feed their baby, just like why am I trying to continue what's not working? (Carly)

These passages from Carly demonstrate the level of frustration she felt associated with her breastfeeding difficulties. She mentioned wanting to give up and handing her infant to her husband. She also questioned why she was continuing to breastfeed when it "wasn't working". These passages demonstrate both the level of stress she experienced, but also her commitment to breastfeeding. She stated that she always came back to breastfeeding despite her frustration levels. Another mother recalled her difficulties in this way:

> I remember calling my brother up and crying and being people keep telling me he's hungry, it hurts when they say it. "He's starving" oh "I think he's starving" … And I was like, I need to talk to Mom and my partner like, I need to ask them stop using the word "starving," which is just a phrase. But, when you're struggling with baby's like percentage weight, you're on the cusp of well are they starving or thriving… And that phrase just becomes so much more weighted compared to just saying on an everyday like ohhh, I'm starving I need a cookie or whatever. (Rachel)

In this passage, Rachel reveals how significant breastfeeding challenges can be for mothers. She acknowledges that it is "just a phrase" but that in the context of her breastfeeding insecurities it suddenly has a different meaning. She reveals the disparity that can be associated with struggling to be able to feed her infant enough to grow and develop properly. This idea of uncertainty in having enough milk was mirrored in mothers' responses, regardless of milk supply. One mother's uncertainty was described this way:

> And it was just absolute misery and so lactation group helped… And that was good to know. I wasn't the only one having difficulties. That was good. Cause I was feeling like, you know a crappy mother who can't feed my child, it hits on a lot of it's a lot of psychology really quickly. (Lauren)

Lauren articulates the intensity of isolation and struggle she was feeling surrounding breastfeeding. She said it was "misery" and that she felt like a "crappy mother" who was unable to feed her child. She communicated the deep levels of pain she felt as a result of her breastfeeding struggles and how quickly it impacted her. She expressed that the group helped her with those feelings because it showed her that she wasn't the only mother who was struggling. The group provided Lauren, and the other mothers, the ability to interact with other mothers who

were in the same situation at the same time. This sameness helped mothers see that they were not alone:

> I had reached a point with Lydia where I was really, I was frustrated. I didn't know what was wrong with our latch. I couldn't get the latch. She was spitting up so much I just couldn't. And that was really worrying me. And people kept saying, like babies spit up, babies spit up. And it was just like frustrating. I felt like I wasn't getting any answers… I felt like I needed help. I wanted to help. I wanted to keep breastfeeding. So, I knew that I needed to reach out for help. (Caitlin)

Caitlin communicates the importance of breastfeeding to her. She acknowledges that she was frustrated, worried and not getting the answers she needed but that breastfeeding was important enough to her to look for solutions and answers. She communicates a certain level of commitment and intentionality to solving her issues so that she could continue breastfeeding.

> But I mean, it was about the best thing I got out of it was probably validation and support that what I was doing was important because sometimes you don't... actually, I had several friends be like, oh, if you're struggling, just give him formula. Like, quit this. Quit this. Why would you do this to yourself? This is crazy. Like, just give him a bottle of formula and like, why are you why are you in tears about this? (Veda)

Veda addresses this dedication to breastfeeding as well. She had friends challenging her to quit worrying about breastfeeding, but that was not something she was willing to give up on. Instead of resolving her issues according to these suggestions, she decided to seek support that validated her efforts as something important. The mothers at this group all encountered struggles throughout their breastfeeding journey, but they remained dedicated to trying to find solutions for these challenges rather than abandoning their efforts to breastfeed. Thus, it is not simply the

struggle that inspired these women to seek change, but also their dedication to breastfeeding. During this phase, mothers began to realize that they were in a condition in which they couldn't remain, and they pursued assistance in hopes of a transformation in their breastfeeding journey.

Phase 2: A Cocoon for the Grappling Mother

The cocoon is a protective shield within which substantial changes are being made (The Academy of Natural Sciences, 2018). The group served as a metaphorical cocoon for these women. To the casual onlooker, the group sounds like a simple gathering, but in reality, the meaning of this support group was quite significant and transformative for these mothers. That is, within the group meeting, small changes were consistently made that ultimately had a large impact on the breastfeeding journey for these mothers. The metaphorical cocoon was not simply a physical place, it was a space comprised of significant others. As a result, the following components of the cocoon are discussed: solutions for the grappling mother, transformation from facilitator to pseudo-family, and comradery in the collective grapple.

The group provided these mothers with a safe space both physically and emotionally. This space allowed mothers to wrestle with their breastfeeding challenges and grow as a result of them. This protected environment provided women with a caring place to seek support:

> Being able to step out of my little bubble in my house and be in like a different safe place where it was like only women and their babies and the people that are there, the lactation consultant that were there to support them. I mean, I feel like even if I didn't need help with breastfeeding, I would go just to be around people that are going through the same like stage in life that I was going through. And other moms that are struggling or moms that aren't struggling and like being able to just see that, like there is a light at the end of the tunnel. (Carly)

Carly reveals the importance of both the physical space as well as the people within the room. She felt safe leaving her home and taking her infant somewhere different. Part of this perceived security was the fact that there were only mothers with their infants and medical professionals present. Thus, it appeared that the combination of healthcare provider and peer support were significant to the group experience. This idea is further expressed by Lisa:

> It was just shocking for me at the time (laughing) and now it's like, whenever… And I was like, you want me to like nurse my baby here? And it was just like so inclusive and so totally normal, like there's no judgment. We're here to help you. We're here to support you and the other moms with the older babies that we're just like laying on the table and, like interacting and playing with toys… and I'm like, oh, my gosh, seems like forever away until my baby's going to be that age and doing those things. (Lisa)

In this passage Lisa, shows the significance of the feeling she had when she entered the group. She reveals that her initial impression was shock. She was shocked to enter a room full of nursing mothers and further surprised by the idea of joining these mothers. This expression of disbelief juxtaposed with the manifestation of normalcy, approval and support displays the value of the individuals within the group. The passages from Liza and from Carly reveal the importance of having a physical safe space that provided a source of emotional support and security in one place. There was more to the group than simply getting help from a medical professional in a safe and clean space. The mothers who entered this group felt instantly welcomed and connected to each other as a result of their desire to seek breastfeeding support:

> Like when you walk into the room, like you're all there for the same reason, you don't need to talk to anybody to know that we're all there for the same reason we want support. And maybe we just want to get out of the house that Wednesday. Or maybe we're having

> a really hard time. We're all in the same boat. And when you walk through that door, you're all equals. I felt like no matter how old your baby is or how young your baby is, like everyone in there is equal, like nobody is on a different playing field. So it's inherently supportive, like you're going to a breastfeeding group. (Veda)

Veda's remarks show the significance of the connections made through breastfeeding struggles. She takes note of the differences she saw within the group but still insisted that they were equals. This juxtaposition suggests that the bond these mothers built in their shared struggles was stronger than any differences they had. There is a certain understanding mothers have as they enter the space, they have confidence that they will be supported and understood by the other individuals present. The mothers were together and connected in their struggles, they were in the same boat and they were all fighting to overcome the obstacles they were facing. This group provided these mothers with a space, a space they could unite and support each other during a time of great uncertainty and difficulty.

This safe space created by the group was made possible by the people within the group more so than the actual room itself; so much so, that the room didn't seem to have much significance for these women. Women rarely mentioned the physical aspects of the rooms that made them feel safe, but rather they mentioned that they felt safe going to the meetings. Once they elaborated on these feelings it was clear that the people within the walls were what made them feel safe. When mothers mentioned the group atmosphere, they discussed qualities of the other mothers and the facilitators that made them feel welcomed when they entered the room. In addition to providing mothers with a safe place to express and voice their breastfeeding battles, it also provided them with a source of possible solutions and strategies. Thus, the group provided mothers with a protected and trusted space to begin transforming their breastfeeding journey.

The Cocoon Holds Solutions for the Grappling Mother. Within this group, mothers found solutions for their breastfeeding challenges. Mothers reported that they had originally sought the support group due to the presence of the healthcare professionals who served as the group facilitators. All of the mothers reported that they started attending because they had gotten to a place where they wanted answers and solutions from a professional. They wanted someone who was perceived as knowing to help them address their unknowns. All of the mothers described the group facilitators as helpful. They helped the mothers find solutions to their issues and answers to their questions. They provided hands-on and proactive support for these mothers by physically adjusting and assessing their breastfeeding relationship. Mothers mentioned that the facilitators not only had solutions, but they had multiple options for them. As a result, the mothers reported that the group facilitators made them feel confident that they could help them. The mothers trusted the facilitators and knew they would be there if/when they needed help.

They were always met with multiple solutions and the facilitators instilled a sense of confidence in the mothers as a result of their attitudes. They never seemed unsure or overwhelmed by the concerns these mothers brought to them:

> They always had. They always had a solution. And they were always very compassionate about finding a way. It was never like, “oh, yeah. That's a real problem.” It was, “Oh, no big. This is the things you could do.” And they always had multiple options, too. Like, it wasn't just like this is where you have to do. I mean, they both gave me multiple things that I could do to fix my problems. (Veda)

In this passage, Veda explains that the facilitators not only had a solution, but that they were compassionate and kind in their delivery. Thus, it wasn’t just about the advice that the facilitators provided mothers, it was about the way these suggestions were communicated. In their delivery,

the facilitators made the mothers feel cared for and understood. Additionally, they made Veda and the other mothers feel like her issues were something that could be solved:

> Just like they never seemed to be struggling with anyone's issues… There was never any like it wasn't like it was never like, "ohh I don't know. I've never seen anything like that before." It was just like yeah this is fine, we've got it. (Kaley)

Kaley's statement furthers the sentiments expressed by Veda. She stated that the facilitators did not seem to be overwhelmed or overly concerned with anyone's issues. In this passage, Kaley moved away from herself and was able to recognize that other mothers had similar experiences with the group facilitators. She was able to recognize that the facilitators not only helped her, but they also helped the other mothers. The fact that the facilitators did not seem overly concerned or unsure, inspired confidence in these mothers. The facilitators always had something to recommend and they never made the mothers feel like their problem was hopeless or that mothers did not have options.

Not only did the facilitators provide mothers with a source of confidence, but also, they made the mothers feel cared for. The facilitators were described as sensitive and nurturing when helping the mothers. They made these mothers feel valued in their concerns:

> They just sat there, and they listen to all my concerns. Everything that I wanted to say never got cut off. I never got. You know, told I was crazy, or I was silly. They really listened. And then gave me really good answers and advice. And I felt comfortable talking to all of them. I wasn't like I only enjoyed talking to one (consultant). That one was helping me. They were all, helpful. (Caitlin)

It was significant to Caitlin that the facilitators listened to everything she had to say, they never interrupted her, and they made her feel like her concerns were valid. As a result, Caitlin felt like

the facilitators could be trusted. The facilitators helped normalize Caitlin and the other mothers' issues.

The confidence and trust these mothers had with the facilitators was expanded by the physical support the facilitators provided. This physical support gave the mothers a model to follow and helped them learn what to do and how to do it:

> And they were like, I remember the lactation consultant, just like grabbing the baby's head and just like shoving him on. And it was like, oh, like you really have that split second to just get it in his mouth. (Kaley)

Kaley recalled an experience where she had a revelation as a result of the hands-on assistance from one of the facilitators. Kaley expressed the importance of being able to watch the facilitator physically move her infant. Her realization demonstrates the value of hands-on assistance from the facilitators. As a result of this added layers of support, mothers were able to learn practical solutions that they could implement on their own.

Mothers expressed that the facilitators equipped them with tools they could use on their own. The facilitators instilled a sense of confidence in the mothers by having successful experiences with them during group meetings. As a result, mothers felt like they had options they could successfully implement on their own:

> They also made me physically do something in the (group), which was great. Yeah, and that helped. Directly got a little bit better. And of course, I was eager to try this at home and then so they also encouraged me really, having to have this positive experience to try at home. (Rachel)

Rachel's passage communicates the importance of having a successful experience at group. Her positive experience at the group instilled confidence in Rachel that she could successfully

replicate at home. The hands-on physical assistance from the facilitators was a notable component to the support received at this group.

The facilitators were a significant aspect of the support group. They served as the facilitators and the initial catalyst towards change and improvement for these mothers' breastfeeding challenges. The facilitators were compassionate and patient with these mothers. They listened to the mothers completely and helped them find solutions to their concerns. In addition to providing helpful advice, the facilitators were able to deliver support for these mothers in a way that was well received and understood. The facilitators also provided mothers with practical, hands-on solutions that they were able to implement on their own. As a result, mothers began to move from a state of despair into a feeling of hope. This transition signified the beginning of their transformative experience within this group. The mothers now had faith in the facilitators ability to help them, which provided them with a sense of confidence. The relationship with the facilitators went beyond that of patient-medical professional. Mothers described their bond with the facilitators as a pseudo-family relationship.

The Cocoon Fosters the Transition from Group Facilitators to Pseudo-Family. These mothers and facilitators started this journey as strangers. They entered the room as individuals and over time they transformed into a pseudo-family. They were sensitive and nurturing to these mothers when they provided assistance. There was a deep level of trust in the facilitator-mother relationship and therefore, the mothers felt comfortable discussing their issues with them. Together the mothers and facilitators were able to solve different problems and mothers felt certain they could rely on the facilitators any time they needed them. This security gave mothers the confidence they needed to tackle breastfeeding battles on their own, knowing they had a network of allies to support them in their time of need. Thus, this group started as a

collection of strangers but turned into a safe space for mothers to make small consistent emotional and physical changes in their breastfeeding journey.

The mothers spoke fondly of the facilitators and even described them as relative-type figures. They were able to provide these mothers with relevant assistance, but they delivered their support in a way that was easily received by these mothers. Several mothers mentioned that they had support from their mothers, but that their support from their mother was not always well received. In fact, several mothers reported that their mother's support caused tension in their relationship:

> … because you reach a point in your relationship with your mother, and you're like is it worth it?... I mean, my mom is fantastic, and we have a great relationship. But, you know, emotions and stress are very high…We were all sleep deprived. And so it just got to a point where it was we needed another set of eyes on everything that was going on in this first week of this child's life. (Lisa)

This passage from Lisa explains the complexities involved with support she received from her mother. She noted that she had a great relationship with her mother and that she was clearly there to help her, but that they needed an outside source of assistance. Her mother was too close to the situation, and Lisa said that both of their emotions and stress levels were high. They needed some help from someone who was removed and not as caught up in the daily circumstances as she was. Lisa was not alone in this sentiment:

> I mean, I don't know, probably moms, every mom is different. But my mom, she would directly throw advice at you and would not kind of take a step back and think, is my advice really good? (Rachel)

Rachel starts by pointing out what type of support she received from her mother. She stated that she would “directly throw advice at you”, which suggests that the advice was not well received or even warranted. Rachel goes on to say:

> ... So this was a not the situation. So, (the facilitators) would not tell you what to do. Because they knew better so umm probably an aunt or somebody who is a little bit more of a distant relative would kind of take a step back and, you know, OK, I'm not somebody who would tell or should tell you what to do. Cause I'm not your mom. (Rachel)

This description shows the importance of the respect and sensitivity the facilitators showed Rachel. She appeared to appreciate the fact that they were somewhat removed and maintained respectful boundaries in their support. They did not overstep and tell mothers what to do, but rather they respected the mother’s autonomy. Rachel finishes this passage by saying:

> … they felt like a relative, somehow, they even though they were a little distant and would take themselves a step back, they still spread this atmosphere of trust. Or this, the feeling that they would be there for you and would be that you would know of them even if you've just met them? Yeah, that was the feeling they kind of gave. (Rachel)

Rachel concludes her statement by using the term “aunt” to describe the facilitators. She was very intentional with this term. This choice displayed the level of closeness and trust she felt towards the facilitators, as well as displaying the space that existed between them. Rachel expressed that the facilitators kept an appropriate distance that provided her with the support she needed without being overly involved. Several other mothers described their relationships with the facilitators as family-like:

> Just very nurturing, very helpful. As as equally as supportive as they were. What's the word? Like giving their professional advice. So like they would give you a lot of

> professional advice, like a doctor, but then they would also be like supportive, like a mother. Too, so with no judgments. (Veda)

Veda used the term “nurturing” which suggests she had a high level of trust and comfort with the group facilitators. She believed them to be helpful and supportive towards her, similar to a mother. She was safe with the facilitators; she trusted their advice and was comforted by their judgement-free support. The role of the facilitators was important to the mothers. There was more than a patient/caregiver relationship between the mothers and facilitators. It was clearly communicated that the mothers’ level of trust with the facilitators was more of a familial-type bond. They were comfortable with the facilitators, and they really felt like they could count on them to help. Mothers spoke fondly of all the facilitators, but there was a facilitator that was singled out by the mothers, Sarah.

Sarah was an important aspect to these mother’s transformation process in the group. The mothers discussed specific qualities in Sarah that stood out to them and that were significant to her ability to help. Most importantly, Sarah was present for these mothers. She was patient, caring and willing to help mother whether it was during the group meeting time or not. She made herself available to these mothers outside of group meetings, which appeared to add a layer of trust and reliance on her.

> One in particular, Sarah. I even reached out to when my baby was my baby just being like super fussy and I didn't know what to do with her. And it just felt like like pseudo mothering in a way. Like they were just here to take care of you and make sure you felt good. (Carly)

Carly’s experiences with Sarah were so meaningful that she referred to it as “pseudo-mothering”. She started in general, discussing the facilitators as a collective and then went more specific as

she began to describe Sarah. Carly is referencing a time in which she reached out to Sarah outside of the group meeting. She felt comfortable enough to contact her in a time of need. This security in the relationship with Sarah is representative of a mother-like relationship. Carly's experience was just one of many:

> Well, I mean, Sarah… was is definitely probably the most mothering and nurturing… I mean, I saw her cry like three times just talking about breastfeeding and helping other women and then knowing… that she is helping other women would make her very emotional. So, yeah, she was she was very nurturing. (Veda)

In this passage Veda demonstrates the level at which Sarah cared about the mothers of the group. Sarah was so passionate and cared so much about the mothers that she was literally moved to tears when talking about her ability to help them. Carly also noted that she was nurturing and motherly which parallels Carly's level of trust and comfort with Sarah. It is clear that these mothers felt a deep connection with Sarah. They singled her out of the group and described her with words weighted with strong emotion.

Mothers discussed their experiences with Sarah and the qualities that made her special to them. They talked about her nurturing presence and how she was able to help ground them:

> It was I swear, it was just like time slowed down and she stayed for probably almost an hour. An hour. I mean, and she was she was right there answering any questions I had. It just went above and beyond what I could possibly have known about what to expect when they said that you're going to you know a lactation consultants gonna come in. (Caitlin)

Caitlin's passage demonstrates the strength of Sarah's presence. That is, Sarah had the ability to slow down time for Caitlin and provide her with quality care. Sarah took the time to sit with

Caitlin and answer all of her questions. The notion that Sarah slowed-down time suggests that Sarah did not rush her interactions with Caitlin and that she was a source of stability during a time of extensive change. She was willing to provide Caitlin with all the time that she needed in a way that was calming and stabilizing for Caitlin.

Sarah appeared to be a person of significance to these moms. It appeared that her willingness to spend her time with the mothers was of utmost importance. She was willing to sit with these mothers for as long as it took, and it was meaningful to them. She was sincere and nurturing towards these mothers and as a result they felt a special bond with her. Though the mothers specifically mentioned Sarah by name, it is important to note that the mothers had positive experiences with all of the group facilitators. Overall, the mothers viewed the facilitators as a source of comfort, support and help. They were able to provide the mothers the care they needed in the way that was well received. That is, these facilitators were sensitive enough to be able to provide mothers personalized care in a manner that made them feel safe and built a relationship of trust. This atmosphere of trust bled into the relationships between the mothers within the group.

The Cocoon Supports Comradery in the Collective Grapple. The facilitators were not the only aspect of the group that influenced the transformation of these mothers. The presence of the other mothers in the group allowed for a sense of community and connection. Mothers realized that they were not alone in their breastfeeding struggles. As a result, the mothers began to move from feeling helpless and overwhelmed by breastfeeding challenges to a feeling of togetherness:

> …you go to the group with the expectation, okay. There will be people, probably, who can either share my experience because it's a group for breastfeeding, so either they share

> my experience, or they will help me. So, when I'm coming home from this group, I'll be a little bit wiser. I'll be more able to cope with my problems that I have…

Rachel went on to say:

> I don't know if you would have this with a friend. Cause it's not. I mean, of course, if it's a good friend, you probably could meet and breastfeed your baby next to each other. But if there are 10 other women, that's different, that's more supportive. It's you're together in this. You're together in the same situation. And the situation is that you are tackling breastfeeding. (Rachel)

This passage reveals the complex levels of breastfeeding support. She notes the fact that having a group of women supporting you is different from having a singular friend. She makes the distinction that having 10 women breastfeeding with you and sharing your struggles is inherently more supportive than having just one friend. Rachel also alludes to the expectation that the group will be able to help her. She has a sense of confidence that when she leaves the group, she will be better off than she was when she entered. She notes the importance of the shared experience. Her entire message references back to the fact that she isn't alone in her struggles and that the comradery experienced in the collective act of breastfeeding in addition to the shared challenges helped improve her breastfeeding relationship. This feeling of commonality between the mothers was a significant component to the support group experience:

> It also made me feel like I wasn't alone as far as with other new moms there. You know, like my struggles, like others were going through the same or similar. I wasn't the only one who was covered in spit up at 3:00 in the morning wondering what was going on, is this normal? So there was some definite camaraderie. (Caitlin)

In this passage, Caitlin expresses that the group helped her feel like she wasn't alone in her struggles, that there were other mothers who were experiencing the same issues she was. As a result, Caitlin felt a sense of mutual understanding and compassion with the other mothers. She was able to voice her concerns and know that they would be met by a mother who was either struggling in the same way or who understood her struggle. This sense of understanding was vital to the bond between the mothers in the group:

> I can't talk about those complex levels of breastfeeding with people who aren't doing it. You can only talk about the complex levels of the feeding that people who are also struggling with it or not, well, understand your motivations. (Kaley)

Kaley's statement expressed the importance of being with other breastfeeding mothers. She described it as a complex issue that not everyone was able to understand. This complexity also revealed the importance of being able to connect with people who are familiar with the different layers involved with breastfeeding. As a result, women were able to relate and connect with each other in different ways than they were connecting with other people. That is, mothers who were not breastfeeding did not appear to understand the motivations behind breastfeeding despite encountering challenges.

The shared difficulties allowed mothers to connect in a unique way. They instantly felt bonded to each other because they had a shared struggle in a common goal: breastfeeding. Their unity was stronger than any differences that typically divide groups. The mothers in this group had mutual respect for each other because they were able to empathize with the other mothers in the group:

> It also made me feel like I wasn't alone as far as with other other new moms there. You know, like my struggles, like others were going through the same or similar. I wasn't the

> only one who was covered in spit up at 3:00 in the morning wondering what was going on, is this normal? So, there was some definite camaraderie. (Caitlin)

In this passage, Caitlin expresses that the group helped her feel like she was not alone in her struggles, and that there were other mothers who were experiencing the same issues she was. As a result, Caitlin felt a sense of mutual understanding and compassion with the other mothers. She was able to voice her concerns and know that they would be met by a mother who was either struggling in the same way or who understood her struggle. Caitlin went on to describe her interactions with the other mothers in the group in this way:

> Connection, I guess. Sort of looks like another sort of way to another way, I suppose I gain you know confidence with that kind of that, the fact that there were others. You know, going through the same things. That we're all, you know, doing the same. Doing similar things. And just how supportive everybody was of each other. (Caitlin)

Caitlin expressed that the connections she made in the group helped her gain confidence. Knowing that she was not alone or that she was not the only person experiencing struggles helped her gain confidence. She was no longer alone in her battles; she had a community of women supporting her. The mothers in this group had a unique bond through their desire to continue breastfeeding despite encountering challenges. Their connection was a source of support that allowed mothers to feel validated in their desire to overcome their breastfeeding challenges. The group provided mothers with a source of unconditional support that helped them take persistent and consistent steps towards making lasting changes in their breastfeeding relationship.

Phase 3: Confidence Emerged from the Grapple

Mothers sought the support of the group in hopes of improving their breastfeeding experience. The evolution of the breastfeeding mother is complex both physically and emotionally. Thus, the experience of these women happened over time and as the result of the specific aspects and processes of the group. The mothers' transformation began when mothers joined the group. From there, confidence grew as mothers found solutions and moved from facilitator-based support to support from other mothers in the group. With this shift from healthcare professional to peer, mothers began to feel a sense of security from both the professional and emotional support offered the group. Thus, the mothers received different levels of support from more than one source.

The mothers in this group emerged from their breastfeeding battles with confidence as a result of the support they received from the group. Mothers had to first reach a point where they felt like they needed to seek support. The facilitators and the other mothers in the group were vital aspects to the change from distressed to confidence these mothers experienced. The facilitators and the other mothers played different roles in the transformation process. Specifically, the facilitators served as professionals who were able to provide mothers with practical solutions and hands-on support for their issues. As a result of the mother's trust in the facilitators, they were able to build confidence in their abilities to solve breastfeeding challenges:

> So, when I started going, that's when I was when my confidence continued to build… I didn't really lose that confidence because I was like, okay, well, I'm gonna go next week and they'll be able to help. And I know I'll get through it and they'll give me… some good advice. And so… once I started to go, my confidence in being able to breastfeed and

> understanding my baby and her cues continued to build, and it just made everything feel better, I think immensely. (Caitlin)

Caitlin explains that the group helped her build her confidence. The facilitators provided her with a sense of stability that she could rely on if and when she needed help. So not only was Caitlin able to build confidence in herself, but she also felt confident that the facilitators would be there when she faced struggles or difficulties. Caitlin's passage also alludes to her personal transformation from breastfeeding being really hard, to self-confidence in her ability to breastfeed and understand her infant. Her conversion from distress to assured is representative of the changes accomplished in this group.

Another important component to the metamorphosis was the other mothers in the group. It appeared that being able to connect with mothers and have a sense of shared struggles helped these mothers gain confidence that they weren't a bad mom, that what they were doing was important and that even though they struggled there was still hope:

> You kind of saw how people interact with their kids and that they all struggle. That was great to see that you are not the only one and that everybody has some issues. And yeah, that was really helpful that you also kind of got that confidence that you're not a bad mom because your baby cries when you're feeding it, that, you know, that's kind of normal at some point for everybody. (Rachel)

Rachel's statement communicates that knowing other mothers struggle provided her with a source of confidence. Her words suggest that before the group she felt like she was a "bad mom", but the group helped her realize that was not the case. Her struggles were normalized by the fact that she wasn't alone which was enough to help her build confidence. Rachel's passage suggests that she experienced a transformation as a result of the group. When she first joined the

group, she did not appear to have confidence in her parenting abilities, but over time, she was able to shift to a place of self-assurance. This transformation is evident in all of the mothers interviewed. Not all of them met their breastfeeding goals, but all of these mothers left the group in a different state than when they joined.

The group provided these mothers with different sources of help in one location. The facilitators and the other mothers in the group played both a vital and unique role in the transformation mothers experienced in their breastfeeding relationship. The combination of solutions and actions recommended by the facilitators and the bond between mothers appeared to provide the support needed for mothers to see a shift in their wellbeing. They served as a source of hope and provided real-time examples and solutions for mothers. The connection between the women, their shared struggles and the support of the group helped women feel more confident. They helped each other build faith in their abilities to breastfeed, to solve problems and overcome challenges. The group appeared to provide these mothers with an important source of connection that helped build a sense of security and unified mothers in their struggles rather than leaving them isolated. The relationships built in this group were valuable and significant to the transformation mothers experienced.

Chapter 5: Discussion

With the use of participant observations and phenomenological interviews, this research study led to a detailed description of the practices, culture and norms of the group as well as the shared transformation of the women attending a breastfeeding support group in the US. Support for breastfeeding mothers has the potential to have a large impact on the breastfeeding relationship for mothers and infants. In order to better understand this potential impact, it is important to investigate the lived experiences of mothers seeking and receiving help. As a result, the purpose of this dissertation was to investigate and provide a better understanding of a healthcare professional facilitated breastfeeding support group and the shared experiences of mothers attending this group. The data from this study revealed important insights into the values of the group that contributed to the collective metamorphosis of breastfeeding mothers.

Several themes emerged from the data with a centralized story of a collective metamorphosis that encompassed the shared lived experiences of the mothers attending the group. This metamorphosis was comprised of different phases (uncertainty, entrance into the cocoon and emerging with confidence) of the mothers breastfeeding journey and the aspects of the group that contributed to the mother's transformation. Specifically, this collective metamorphosis began with mothers experiencing uncertainty in the unknowns associated with breastfeeding. They realized they were in a position they couldn't remain in and sought the support of the group studied. The group served as a metaphorical cocoon, as it provided mothers with a safe space to go through a process of growth. Specifically, this cocoon provided mothers with the opportunity to find solutions for their struggles from a trained lactation consultant. As mothers entered this relationship, they found the facilitators to be a source of trusted care they could rely on. The facilitators transcended from medical professionals to a pseudo-family role.

This trust in the facilitators transferred to the group to foster an environment of reliable and sensitive support. This safe environment allowed mothers to find a source of connection within their shared struggles. The bond between the mothers helped them transform from a state of isolation to a sense of community in a shared experience. These unique qualities of the group cocoon provided mothers with the space to move from a state of uncertainty to confidence. Thus, the different phases of the story in partnership with the defining qualities of the metaphorical cocoon allowed mothers to experience a breastfeeding metamorphosis.

There were several aspects of the group that aided in developing the unique culture of the group as well as the values that protected and fostered the growth of the mothers attending the group. Both the healthcare professionals and mothers played valuable and specific roles within the group and the help mothers received from the group. That is, having both peer and healthcare professional support in one location appeared to be critical features of the group. The facilitators guided the group and the processes within it. They helped make the value of respecting mothers and their motivations to breastfeed a cornerstone of the group experience. Group facilitators set an example for the mothers within the group to follow. They were sensitive to the needs of mothers and were intentional in the ways in which they delivered to care mothers. Facilitators also encouraged mothers to share their experiences with one another which aided in the sense of comradery between mothers. Within this group, mothers were able to obtain solutions and answers from medical professionals at the same time they were able to build a network of support from other mothers who were going through the same phase of life at the same time.

Another critical element of the group was the atmosphere of trust established through the practices and values of the group. These customs and principles allowed the group to transform into a safe space for mothers to grow and make changes throughout their breastfeeding journey.

The group respected breastfeeding, maternal needs and wellbeing, the importance of peer support as well as physical and practical help. Mothers felt encouraged by and bonded to both the facilitators and their peers in the group due to the mutual understanding of their motivations to and the significance of breastfeeding. This shared belief that breastfeeding is meaningful and beneficial despite facing challenges, allowed mothers to feel a sense of community and hope rather than distress. The group allowed mothers to find a sense of connection in their struggles and provided mothers with physical and emotional care in one location.

While this group provided a space for meaningful transformation for the mothers in attendance, it is important to note that the sample in this study was a homogenous group. For the most part, the participants were mothers with high levels of income and high levels of education. They were all privileged enough to be able to attend a group in the middle of the day on a working day. This group, while incredibly meaningful to the mothers present, is not a source of support that would likely work for the wide array of mothers who are struggling with or needing assistance in their breastfeeding relationship. Further research is needed to better understand the implications groups of this nature could have in more diverse contexts. Below I will discuss theoretical perspectives and previous research as it relates to the findings of the present study as well as implications for further research and policy.

Links Between Theoretical Perspectives and Findings

The findings of this study are consistent with several theoretical frameworks. Due to the nature of the research questions, symbolic interactionism is applicable to both the findings and the methods used. Additionally, phenomenology was utilized as a guiding framework for both the methods and the interpretation of the findings. Consistent with the tenants of existential phenomenology, the findings of this study can be understood through body, time, others, and

world. The transformation of the participants can be further understood by the principles of transformative learning. The connections with symbolic interactionism, existential phenomenology, and transformative learning will be discussed in more detail below.

Symbolic Interactionism

Symbolic interactionism operates under the assumption that humans generate meaning based off their interactions with the world around them. More specifically, there are three key beliefs associated with symbolic interactionism: humans act according to their personal meanings of the world around them, the meanings develop from social interactions, and these meanings are used to inform future interactions (Blumer, 1986). All three of these principles are relevant to the experiences of the women participating in the support group. Mothers in this group had a strong emotional and intellectual connections to the breastfeeding relationship. A lot of the mothers mentioned that their beliefs surrounding breastfeeding originated from their childhood as well as their interactions with their mothers, siblings and friends throughout their life. These interactions were influential factors that shaped how these mothers viewed and related to breastfeeding. As mothers began their breastfeeding journey, they noted that their understanding of the breastfeeding relationship changed.

Mothers mentioned that they dealt with contradictions between their expectations of breastfeeding and their actual experiences with breastfeeding. When they experienced inconsistencies, mothers sought the support of the group. Consistent with the tenants of symbolic interactionism, these social interactions helped mothers develop new meanings of breastfeeding that influenced both short- and long-term breastfeeding choices (Blumer, 1986). The social interactions within the support group and the relationships from this group influenced the mother's ability to continue breastfeeding as well as impacted their short-term and long-term

breastfeeding practices. That is, as mother's experiences contradicted their beliefs, mothers were able to find a new understanding of breastfeeding as a result of the group. Thus, mothers gained the ability and confidence needed to address issues on their own. The mothers in this study demonstrated how their interactions with the world around them influenced their beliefs and the meanings they associated with breastfeeding as well as their ability to make decisions surrounding their breastfeeding relationship.

Symbolic interactionism suggests that humans base their actions off their meanings of specific facets of their world (Blumer, 1986). The significance of breastfeeding to these mothers was evident by the way they discussed their experiences. They explained deep levels of despair as a result of their early breastfeeding relationship. The struggles encountered weren't necessarily major issues, but the way the mothers interpreted and internalized these challenges was central to gaining insight into and better understanding of the experiences of these mothers. Within symbolic interactionism, it is important to consider these personal meanings in order to form a deeper understanding of a behavior (Blumer, 1986). Some mothers felt like they were failing or that they were a bad mother because they were having issues breastfeeding. This deep level of despair demonstrated how their meanings of these occurrences influenced the ways in which mothers navigated their breastfeeding relationship. Without this added layer of meaning, it would be difficult to understand what inspired mothers to seek help outside of their immediate resources. Knowing that mothers felt like failures or "bad mothers" as a result of their challenges provides much needed insight into their motivations in joining the group as well as the impact of the solutions found at the group.

Lastly, symbolic interactionism implies that meanings develop from an individual's interactions with the world around them as well as the ways in which other individuals interact

with the world around them (Blumber, 1986). That is, individuals derive meaning from the ways other individuals interact with the world around them in addition to the way's individuals interact with each other (Blumer, 1986). Mothers attending the group were able to transform their breastfeeding relationship as a result of many factors including, but not limited to, the interactions they had with the other mothers in the group as well as their observations of the other mothers in the group. As a result of these relationships, mothers expressed that they were able to be more open and better understood by the mothers in the group when compared to non-breastfeeding mothers/friends. Additionally, mothers noted that they were able to learn from and find encouragement from watching the other mothers interact with their infants. Mothers were able to learn from each other by mimicking certain behaviors and by asking each other for advice and discussing personal experiences. Thus, this group allowed mothers to both witness the ways in which other mothers interacted with their infant and they were able to engage in social interactions with other mothers in meaningful ways that influenced their breastfeeding relationship.

The breastfeeding support group and the individuals within it provided an important example of how symbolic interactionism can be used to better understand the experiences of breastfeeding mothers. By learning the ways in which mothers ascribed meaning to breastfeeding and to their challenges allowed for valuable insights into why mothers were determined to continue to breastfeed despite their struggles. The emphasis on individualized meanings provided a better understanding of how the breastfeeding relationships evolved within the group as well as the significance of having a space to interact with other mothers who are going through similar difficulties.

Existential Phenomenology

Existential phenomenology is rooted in philosophy and is grounded in the idea that understanding and explaining humans and the world we live in cannot be done from the outside (Matthews, 2006). Breastfeeding provides a unique opportunity to examine from multiple perspectives. The present study provided insights into the "outside" world of breastfeeding through observations and the interviews provided insights into the internal world of breastfeeding mothers. Uncertainty, struggles and determination are pinnacles of the story told by the mothers in this study. By sharing their expectations, perceptions and feelings surrounding their breastfeeding relationship, this study provided insights into the aspects of breastfeeding that both challenge and motivate mothers. This study brings awareness to the internal world of breastfeeding mothers and the significance it has on the breastfeeding journey.

Merleau-Ponty argues that objective understanding is derived from human actions performed for particular purposes and, as a result, human experiences are the source of meaning (Merleau-Ponty, 2002). Breastfeeding is an important relationship centered around providing nutrition to aid in the growth and development of infants. The findings of the present study further the idea that breastfeeding is a source of deep meaning and significance to breastfeeding mothers. The value and importance of this infant feeding relationship was best emphasized through the stories mothers shared about their breastfeeding journey. Their detailed accounts of the physical and emotional aspects of the relationship provided a better understanding of the motivation and determination of these mothers. By better understating the driving forces behind maternal breastfeeding actions, we begin to find new meaning of breastfeeding rates and how to better support mothers breastfeeding goals. The findings of this study support the idea that

meaning and perspective originate from purposeful actions and the experiences of the individuals performing these actions.

Humans interact with and exist within the world around them and phenomenology aims to examine the tools individuals use to understand and connect with the world and people around them (Matthews, 2006). This study revealed the importance of the quintessential tool, the support group, mothers utilized to navigate their breastfeeding journey. Within the group, there were several resources employed by the mothers to overcome their struggles. The findings demonstrate the importance of not only having access to breastfeeding assistance, but also having access to care that provides different avenues of help. Mothers within the group were able to derive new meaning of their breastfeeding relationship as a result of the resources available to group members. These interactions and the use of the group resources, mothers were able to experience a breastfeeding metamorphosis.

Phenomenology is centered around describing the essence of particular experiences (Merleau-Ponty, 1996). This study was solely focused on presenting a detailed account of the shared lived experience of those participating in the group. The metaphor of the breastfeeding metamorphosis presented in the findings depicts the spirit of the group experience. Mothers entered the group in a particular state of being and by the end of their attendance in the group, mothers emerged with confidence. This transformation demonstrates the importance of tools employed by the group as well as the interactions within the group that fueled the way mothers defined and internalized their breastfeeding journey. Utilizing the personal accounts of mothers allowed the results to report the heart of what this group meant to mothers and how it influenced their understanding of what it means to be a breastfeeding mother.

Transformative Learning

Transformative learning is a theory most often used with adult learning in an effort to aid in the development of autonomous thinking (Mezirow, 1997). According to Mezirow (1997), transformative learning is the process of inspiring change in an individual's "frame of reference". These frames of reference are made up of assumptions by which individuals understand their experiences (Mezirow, 1997). Mothers in this study revealed the significant impact their frame of reference had on their breastfeeding relationship in the early postpartum period. They had developed a certain expectation about breastfeeding as a result of the information they gathered beforehand as well as their social interactions with other mothers regarding breastfeeding.

Mothers went into the breastfeeding relationship with a framework for how the experience should go, but as they began breastfeeding their beliefs were challenged. This inconsistency led mothers to feel distressed and overwhelmed with breastfeeding which led them to seek the support of the group. Within this group, mothers were able to undergo a metamorphosis that shifted their frame of reference by learning, applying new skills and engaging in purposeful social interactions. This transition signified a shift in their reliance on expectations set forth by others to a focus on their new confidence and abilities to solve issues on their own. A newfound certainty in breastfeeding changed the way these mothers understood breastfeeding and consequently the way mothers experienced their breastfeeding relationship.

Individuals transform their frame of reference by reflecting on the assumptions that influence their interpretations, beliefs, and points of view (Mezirow, 1997). Mothers encountered challenges that were contrary to what they believed to be true about breastfeeding. By seeking the support of the group, mothers entered the metaphorical cocoon that promoted both individual and group reflection. Mothers were able to seek one-on-one assistance with professionals in a

safe space. During private and group interactions mothers were able to reflect on their experiences and challenges; as a result, mothers received supportive feedback that helped in changing their point of view. The state of the mothers' emotional wellbeing transformed from a state of uncertainty to a belief that they had the skills to address their struggles. Interactions with other mothers in the group allowed mothers to shift their interpretation of their breastfeeding relationship. Mothers shifted from believing they were alone into feeling a sense of belonging and community as a result of their shared difficulties.

Transformative learning views social processes with discourse as a significant aspect of creating meaning (Mezirow, 1997). A significant component of the transformation these mothers experienced was a result of social interactions with meaningful communication with other mothers and the group facilitators. These exchanges provided mothers with a new meaning of what it meant to be a breastfeeding mother. A key component to transformative learning is that new information must be incorporated into a well-established frame of reference (Mezirow, 1997). The mothers in this study entered the group with a deep-rooted set of beliefs and meanings attached to breastfeeding but they were able to change their breastfeeding frame of reference. The group gave mothers the opportunity to interact with others in a safe space that fostered the growth and the incorporation of new information into their meaning of breastfeeding. Through interactions with influential others, mothers were able to incorporate new information into their frame of reference and, as a result, their meaning of breastfeeding was transformed.

Relationship to Previous Research and Findings

There were several connections between the findings from this study and the results of earlier research related to breastfeeding. The present study furthers the findings of previous

research and adds a fresh look at what it means to be a breastfeeding mother. Valuable insights from the findings of this study as it relates to previous research are discussed. Specifically, the literature associated with early cessation of breastfeeding and the importance of support are addressed.

Early Cessation

The mothers in this study did not discontinue breastfeeding in the early phases of their breastfeeding relationship, but the factors influencing early cessation are relevant to the story of the mothers in this study. Inconsistencies between mother's breastfeeding expectations and their personal experiences have been associated with early cessation of breastfeeding (Moore & Coty, 2006; Mozingo, Davis, Droppleman & Merideth, 2000; O'Brien, Buikstra & Hegney, 2008; U. S. DHHS, 2011). Mothers in this study reported a difference in their expectations and the reality of breastfeeding. They noted that their belief that breastfeeding would be natural and easy made it more difficult when they encountered challenges. Mothers felt isolated and despaired early in their breastfeeding relationship. This early distress pushed mothers to seek support during this critical time rather than ending their breastfeeding journey. Thus, the early struggles resulting from a disconnect in expectations and reality are consistent with the notion that these inconsistencies have a significant impact on the breastfeeding relationship.

Early cessation is also related to different issues mothers encountered during the beginning stages of breastfeeding. Challenges related to inadequate milk supply, latching difficulties, and painful or clogged milk ducts have been associated with early termination of breastfeeding, unless they received professional assistance (Bunik et al., 2010; Heinig et al., 2006; McInnes & Chambers, 2008; Taveras et al., 2003; Thulier & Mercer, 2009). Mothers in this study reported encountering all of these difficulties. In fact, they regularly cited that similar

issues pushed them to seek help from the group. As a result, the mothers in this group were able to find solutions to their difficulties rather than ending their breastfeeding relationship. The women in this study were able to obtain professional support that was transformative for their breastfeeding relationship. Thus, the experiences of these mothers support the idea that professional assistance may discourage early termination of breastfeeding.

Importance of Support

Peer support has been cited as a source of important support for breastfeeding mothers. A discourse analysis revealed that both group and individual breastfeeding support normalized breastfeeding by making it a part of daily life (Burns & Schmied, 2017). This type of support helped normalize breastfeeding challenges and were seen as a source of hope that problems could be solved (Burns & Schmied, 2017). The findings of the present study further the idea that peer support helps mothers realize that breastfeeding issues were normal and that these difficulties could be overcome. Mothers found a source of connection through their suffering and were able to find hope for progress in the future as a result of their interactions with the groups. The findings of this study support the notion that peers help normalize breastfeeding in a way that promotes the possibility of solutions.

Peer support has also been reported as a more experience-based approach as opposed to a knowledge-based approach (Burns & Schmied, 2017). This experience-based approach is thought to provide women with a sense of community and connectedness (Burns & Schmied, 2017). Mothers in the present study all reported that they felt a sense of community and connection to the other mothers in the group as a result of their shared life experience. They reported that being able to be with mothers who were in the same phase of life at the same time provided a level of understanding and support that they were otherwise missing. Thus, this study

expands on the idea that peer support provides a unique type of help that is valuable to the breastfeeding relationship. As a result of the bond mothers formed, they felt like they were safe to express themselves and could trust the other members in the group.

Trust is an important part of receiving effective breastfeeding assistance. A metasynthesis with both formal and informal breastfeeding support discovered that women described authentic and individualized support from people they trusted to be most effective (Schmied, 2010). Findings from the present study emphasizes the importance of genuine and personalized help. The mothers in this study described how the atmosphere of trust in the group allowed them to feel understood and heard in their struggles. Mothers noted the importance of being able to depend on the group to provide them with assistance when they were in need. Their confidence increased because they knew they had dependable support from the group. Furthermore, mothers expressed that having the individualized help from the facilitators allowed them to receive physical and practical solutions for their personal difficulties.

Lastly, previous research has found that receiving support from multiple sources is important. A metasynthesis of qualitative data from breastfeeding mothers discovered that mothers believed it was valuable to receive support from multiple sources (Nelson, 2006). This study provided insight into a group that was able to offer mothers different types of support from more than one source. Mothers were able to receive group support, peer support and healthcare professional support in one location. Additionally, mothers were able to receive medical advice, experience-based assistance and physical, hands-on feedback. Each of these components were significant to the mother's experiences and their breastfeeding transformation. They noted the how each of these sources and types of assistance provided them with valuable knowledge and guidance that helped them improve their breastfeeding relationship. mothers also noted how all

of these sources helped build their confidence in their abilities to solve their breastfeeding difficulties.

Implications for Further Research

The findings of the present study demonstrate the importance of further examining the personal experiences of breastfeeding mothers seeking face-to-face healthcare professional peer support groups. Gaining insights into which unique characteristics of these groups influenced the breastfeeding relationship is valuable information on how to best support breastfeeding mothers. It's important to obtain more detailed information about the different components of the group. A study focusing on these aspects would provide valuable insights into how we can better help breastfeeding mothers and potentially increase the rates of breastfeeding.

The present study brought forth some inconsistencies with earlier research. A metasynthesis of informal and formal peer and professional breastfeeding support found that mothers thought healthcare professionals reduced their confidence in their ability to successfully breastfeed (Schmied et al. 2011). The mothers in this study reported a strong sense of trust and confidence in the healthcare professionals at the group. These healthcare professionals were all lactation consultants and appeared to provide mothers with different assistance than the postpartum nurses. Mothers described the postpartum nurses as more of a task-oriented style of assistance. They also reported that the other medical professionals they sought support from weren't able to provide them with solutions for their issues. Thus, it would be important for future research to investigate how support from different types of healthcare professionals impact the breastfeeding relationship.

Mothers in this study reported a stark contrast between their breastfeeding expectations and the reality of the process. They noted that breastfeeding was different in theory than in

practice, and as a result they felt unprepared to handle the difficulties they faced. A systematic review including 25 studies with 10,056 women and 20 studies with 9,789 women examined the impact of prenatal breastfeeding education on breastfeeding rates (Lumbiganon, Martis, Laopaiboon, Festin, Jo & Hakimj, 2011). Overall, the review did not find evidence that breastfeeding education improved initiation or duration of breastfeeding (Lumbiganon et al., 2011). The mothers in the present study suggested that prenatal breastfeeding education did not adequately prepare them for their breastfeeding experiences. Future research should look into which particular aspects of breastfeeding mothers feel unprepared for and how to better equip them for those facets of breastfeeding.

Current research largely looks at infant feeding practice in terms of breastfeeding and not breastfeeding. Mothers are currently engaging in more diverse feeding practices than research and discourse might suggest. It is important to acknowledge that mothers are providing a combination of breast milk and formula as well as engaging in pumping, bottle feeding and nursing. Thus, future research should be sensitive to these complexities of infant feeding practices. Furthermore, it's worthwhile to be aware the reasons mothers are engaging in these various feeding styles. Some mothers engage in a combination style of feeding out of desire for the other parent to be able to feed the infant, an infant may refuse to nurse or refuse to take the bottle, an infant might have a deficiency that is best met with formula or a mother might have issues with milk supply. Infant feeding practices are complex and versatile and it is important that future research and discussions adequately depict the diversity in infant feeding practices that exists.

Implications for Practice

The importance of the individual and the context in which they exist cannot be ignored. According to the 2020 Breastfeeding Report Card, Non-Hispanic black mothers are disproportionately less likely to initiate breastfeeding and are even less likely to meet the AAP recommendation of exclusive breastfeeding through 6 months (CDC, 2020). Disparities in breastfeeding rates were found between mothers with lower levels of education and those with higher levels of education as well as mothers living in poverty and those with higher house-hold incomes (CDC, 2020). Infants living in the Southeast of the US are less likely to be breastfed at 6 months when compared to infants living in other regions of the country (CDC, 2020). Therefore, it is important for breastfeeding initiatives to consider the accessibility of resources and policy protections.

Appropriateness of support and policy is of utmost importance. A breastfeeding support group, such as the one in the present study, is not going to be a source of help that is well received or practical for all mothers. Mothers returning to work may not be able to leave and attend a support group during the middle of the day. Thus, it is important to consider the mothers who are in need of assistance but don't have the ability to leave work or reasonably access some of the resources available to them. Mothers living in poverty with lower levels of education are more likely to experience pressure to return to work and are less likely to have jobs that provide protections for mothers. Thus, in order to best serve mothers and increase breastfeeding rates, policies and interventions must adapt to maternal circumstance.

Mothers with higher household income levels are more likely to be able to afford taking time off from work regardless of maternity policies. Mothers living in poverty might feel more pressure to return to work and are likely to have jobs that do not provide access to paid maternity

leave. Thus, mothers living in poverty might return to work earlier than mothers with higher income levels. Offering paid maternity leave could provide mothers with lower income levels, single mothers and mothers with lower education levels the opportunity to have more time to establish a strong breastfeeding-relationship and/or access support they won't be able to utilize once they return to work.

Maternal work environment and policies are associated with breastfeeding duration (Guttman & Zimmerman 2000; Hawkins et al., 2007; Johnston & Esposito, 2007; Kimbro, 2006). A national sample of the three largest cities in each state in the U. S. (including Washington, DC) revealed that only 2 of the 151 (1.3%) cities had specific legislation that detailed protections for breastfeeding women in the workplace (Froh et al., 2018). This lack of maternal protection in the work environment highlights an important gap in mothers' abilities to continue breastfeeding when they return to work. Mothers returning to work often face inflexibility in their workplace and have few protections. Policies that protect break time for new mothers and provide private spaces for pumping and/or nursing at work could encourage breastfeeding for working mothers.

Family leave policies would also be a worthwhile consideration. Not all families have both a mother and a father, general familial leave policies could help support families with single fathers as well as LGBTQ couples. It is important to consider how current policies impact not only breastfeeding mothers but also the care of newborn infants living in the US. Financial support for families with newborns could help alleviate the pressures for new parents to return to work early. Specifically, financial support provided for low-income families could provide new parent/parents the freedom to utilize programs and support developed to promote breastfeeding and help new parents cope with the demands of caring for an infant.

In addition to paid family leave policies, it would be valuable to consider programs that provide paid care visits with healthcare professionals. Government subsidies for healthcare professionals to provide weekly and/or bi-weekly home visits for new mothers could help low-income mothers' access professional support. Paid home visits from lactation consultants or health care professionals could encourage and help women overcome the barriers they face once they leave the hospital. Furthermore, this type of program might help normalize professional assistance, which might make it more likely for mothers to seek support when they need it.

Breastfeeding rates are complex both on the individual level as well as the national level in the US. There are several factors that influence a mother's ability and desire to and duration of breastfeeding. Thus, it is important for breastfeeding policy and interventions to be sensitive to the varying needs of mothers based on their individual context. No one resource could be appropriate and accessible for all mothers, thus it is important to approach breastfeeding support with a multifaceted plan that is applicable for mothers living in different circumstances. It is also important to note that mothers are feeding their infants in a multitude of ways. Mothers aren't simply breastfeeding or not breastfeeding, mothers are breastfeeding, formula feeding, exclusively pumping, and doing a combination of breast milk and formula. Moving forward it is important that resources and support for mothers are relevant and appropriate for the diverse styles of infant feeding practices mothers are engaging in.

Role of Researcher

Due to the personal nature of the study and my level of involvement with the group, it is important to acknowledge my experiences and processes throughout the data collection and analysis process. As previously mentioned, prior to collecting data I participated in a bracketing interview with the PRG, which was analyzed by the group with me in the room. I was only

allowed to enter the discussion to answer clarifying questions. This process proved to be very valuable and challenging on a personal and professional level. Not only did it provided me with valuable insights into areas of bias I needed to bring awareness to when interacting with the participants, but also it provided me with the unique opportunity to view my experiences and beliefs from an outsider's perspective. This new perspective helped me to find a new level of understanding of my personal breastfeeding experiences and beliefs as well as gave me the opportunity to notice how others respond to my words. It was alarming to witness the level of intensity at which I expressed myself and the difficulties I had experienced while trying to breastfeed my infant and complete this study.

There were several pros and cons to being a breastfeeding mother studying a breastfeeding support group. It allowed me to have more of an insider's role and perspective, which I believe allowed me to develop relationships of trust with the other women in the group. I was seen as a peer who was struggling through the same phase of life as the other mothers. I think this level of trust was displayed in the depth mothers provided in their interviews. Though I viewed this as something that helped strengthen the data, I also saw it as a challenge personally. Each time I attended the groups I felt the strain of being caught between the role of researcher and the role of breastfeeding mother. I struggled greatly with my breastfeeding relationship and was in need of support from the group, both from the facilitators and the other women in the group. I had issues with my supply and as a result of my challenges I began to struggle both personally and professionally. I had feelings of doubt surrounding my ability to feed my child and my ability to be an advocate for and researcher of breastfeeding if it was something that I wasn't able to do with my own child.

This strain between my role as a researcher and role as a mother ultimately provided me with a new perspective through the analysis process. Prior to breastfeeding my infant, I had no way of truly understanding the difficulties mothers encounter during their breastfeeding relationship. As a result, I felt a tremendous responsibility to accurately tell the collective story of the mothers attending this group. I found a new level of passion and care for breastfeeding mothers and their experiences. I believe that being a breastfeeding mother throughout this study provided me the opportunity to connect with the data on a deeper level than I otherwise would have been able to. I was able to understand and relate to the experiences of these mothers and in turn I believe I was able to provide a richer description of the group and the shared lived experiences of the mothers.

Strengths and Limitations

This study has several strengths that add to its value and implications of the findings. One of the major strengths of this study relate to the methods. The present study utilized both participant observations and phenomenological interviews. The combination of these two methods provided valuable insights into both the function and qualities of the group meetings and the personal experiences of mothers participating in the group. Data from the interviews helped with the analysis of the observations and vice versa. That is, because there were two sources of data it helped make the significance of the observations more evident. For example, within the field notes it was frequently noted that facilitators helped mothers find new holding positions. The significance of the different holds was further emphasized through the interviews. Mothers expressed the impact that the positions made on their breastfeeding journey, which would not have been present by the observations alone.

Another strength of the methods is the extended time I spent in the field. As a part of my participant observations, I entered into and spent lengthy time with the group. My consistent presence in the group allowed me to build relationships with both the mothers and the group facilitators. These relationships were the foundation for a trusted relationship through which mothers felt comfortable sharing in-depth details of their group and breastfeeding experiences. An important component of phenomenology is having rich personal details and the extended time I spent with the group helped accomplish this goal. Lastly, my extensive time with the group allowed me to see the group evolve over the course of nearly a year. Due to this length of time, I was able to better note aspects of the group that changes and remained consistent over time.

My participation in the Phenomenology Research Group is a major strength of the present study. This group not only provided me with invaluable feedback and support throughout the data collection and data analysis process, but also it established a level of rigor that otherwise would not have been present. The members of this group were active in my study from beginning to end. They gave me valuable insights into my personal biases and beliefs that I needed to be aware of during the data collection process. I presented a pilot interview which allowed the group to critique my interview skills and give me advice on how to improve abilities. Members of the group analyzed and discussed four total transcripts. Once I was finished with data analysis, I presented two rounds of themes to the group. Each time they offered advice on how to better tell the collective story of the mothers interviewed. The PRG was an integral part of the study and delivered a layer of value to the study that would have otherwise been missing.

Lastly, the present study is the only study that has investigated a face-to-face healthcare facilitated breastfeeding peer support group. As a result, the findings provide valuable insights

into the significance of groups with this unique structure. The literature suggests the importance of face-to-face support, healthcare provider support and peer support; thus, having all of these in one location offers a rare source of support that little is known about. Additionally, the qualitative methods used allowed for a rich description of the group values, practices and norms as well as detailed account of what it meant to be a mother participating in the group.

Though there are several significant strengths to this study, it is important to note that there are limitations. The most pressing limitation was related to COVID 19. During data collection the COVID shutdown brought a temporary end to the group meetings and resulted in policy changes for attendance once the group started meeting again. As a result, my participant observations were cut short. I wasn't able to engage in as extensive recursive process as I had originally planned. It is important to note, that the nature of the methods did provide me the flexibility needed to be able to continue collecting data despite the challenges resulting from the COVID shutdown.

The sample was largely homogenous. Though the group was free to the public and associated with a local hospital, the participants in the study formed a homogenous sample. The participants were highly educated mothers with middle to higher level household incomes. Maternal and facilitator racial and ethnic identities were not explicitly collected or stated. As a result, there is an assumed whiteness to the participants of this study. Some mothers offered their self-identified ethnic identities, but since every mother did not report this it was not discussed. Though this sample is not diverse, it is important to note that these demographics are representative of the current breastfeeding rates. Mothers with higher levels of education and income are more likely to breastfeed and to breastfeed for longer. Thus, it is not surprising that the sample had these particular characteristics. It is also important to consider the aspects of the

group that contributed to this homogenous sample. The group was in the middle of the day on a Wednesday. Being able to attend a breastfeeding support group in the middle of the week limited the accessibility for many mothers.

Not collecting self-identified racial and/or ethnic identities was a large limitation given what we know about disparities in current breastfeeding rates. Non-Hispanic White mothers have the highest exclusive breastfeeding rates with non-Hispanic Black and Hispanic mothers having the lowest exclusive breastfeeding rates. These rates could have led to the assumption that the participants in the group would largely identify as white, which also eliminates the opportunity for diversity to be found and expressed throughout the findings. I was hoping there would be more diversity within the group due to the fact that it was free and attached to a local hospital, but this was not the case. This could be due to the fact that the hospital was located in a high socioeconomic area of town with less racial diversity than in other areas of town.

This group was open to the public and free to any mother who wanted to attend, but there was not any advertisement for the group. Most mothers found out about the group through word of mouth or by delivering at the hospital it was housed in. The hospital the group existed within a high-income area of town. Therefore, it may be more likely that mothers who delivered at the hospital are from the surrounding high-income neighborhoods. Lastly, the idea of publicly breastfeeding in a small southern town in the US could be a deterring factor in and of itself. The group required mothers to not only be motivated to seek the support of the group but also to be willing and vulnerable enough to breastfeed in public with a group of strangers. While there is opportunity for diversity within the group because it is free, it is important to note that there are aspects of the group that contribute to the homogeneity of the sample.

Another limitation is related to the participants willingness to participate and the exclusion of distressed mothers. It is possible that the mothers who were willing to discuss their experiences with me were the individuals who had a positive experience with the group. Additionally, mothers who were in clear distress were left out of the observations and were not asked to participate in the study. Though these women were given their privacy for important ethical reasons, it is relevant to note that their experiences were not included in data collection process. Their experiences both observed and self-reported could have provided more in-depth insight into the difficulties and struggles mothers' experiences, as well as adding more variety to the maternal experiences. In addition to the ethical reasons, the majority of mothers who were clearly distressed during the meetings did not meet the inclusion criteria for attending enough meetings. It was important for participants to be regularly involved with the group, but by setting this criteria it could have biased the findings to be more positive. Additionally, by omitting the distressed mothers from the observations, there was an entire aspect of the facilitators role that was left out of the findings. This facet of the facilitators role and interactions could have provided valuable insights into the values, practices and norms of the group.

Conclusion

Breastfeeding is a complex process that involves physical and emotional demands (for metasynthesis see Nelson, 2006) and is associated with health benefits for both mother and infant (Bernier et al., 2000; Chung et al., 2007; Collaborative Group on Hormonal Factors in Breast Cancer (CGHFBC), 2002; Dermer, 2001). Despite the advantages associated with breastfeeding, the US is currently failing to meet the recommendations set forth by the American Academy of Pediatrics and the World Health Organization (U.S. Department of Health and Human Services (U. S. DHHS), 2011, WHO, 2018). Several factors impact breastfeeding rates including, but not

limited to, adequate family support, peer support, social context, perceived support from husbands/partners and maternal work circumstances (Arora et al., 2000; Brodribb, Fallon, Hegney & O'Brien, 2007; Dennis, Hodnett, Gallop & Chalmers, 2002; Foster, Slade, & Wilson, 1996; Guttman & Zimmerman 2000; Hawkins, Griffiths, Law & Millennium Cohort Study, 2007; Johnston & Esposito, 2007; Kimbro, 2006; Kong & Lee, 2004; Rempel, 2004). Therefore, in order to better understand how to best support and help breastfeeding mothers, it is important to gain in-depth insights into maternal breastfeeding experiences.

The collective story of the mothers participating in a face-to-face healthcare facilitated breastfeeding support group is one of metamorphosis. The mothers attending this group were in a phase of life filled with rapid change and transformation. Unique qualities of the group and the personal experiences provide valuable insight into what it means to be a breastfeeding mother experiencing challenges and seeking support as a result. By listening to and bringing voice to their collective story, light was shed on the essence of the meaning and significance of this support group.

The mothers in this group served as a source of support, validation and hope for each other. There was strength found within the vulnerability and bond that emerged from a shared struggle. Mothers within this group displayed a sense of determination and strength in their ability to persevere despite challenges. Without their willingness to share their stories these important findings would not be possible. As a result, it is my hope that their story will help inform future research and policy that improves the care and support breastfeeding mothers receive in the years to come.

References

Arora, S., McJunkin, C., Wehrer, J., & Kuhn, P. (2000). Major factors influencing breastfeeding rates: Mother's perception of father's attitude and milk supply. *Pediatrics*, *106*(5), e67-e67.

Asiodu, I. V., Waters, C. M., Dailey, D. E., & Lyndon, A. (2017). Infant feeding decision-making and the influences of social support persons among first-time African American mothers. *Maternal and child health journal, 21*(4), 863-872.

Bernardo, H., Cesar, V., & World Health Organization (2013). Long-term effects of breastfeeding: a systematic review.

Bernier, M. O., Plu-Bureau, G., Bossard, N., Ayzac, L., & Thalabard, J. C. (2000). Breastfeeding and risk of breast cancer: a meta-analysis of published studies. *Human Reproduction Update*, *6*(4), 374-386.

Binns, C., Lee, M., & Low, W. Y. (2016). The long-term public health benefits of breastfeeding. *Asia Pacific Journal of Public Health, 28*(1), 7-14.

Binns, C., Scott, J., Forbes, D., Hewitt, K., Pasalich, M., Davies, P., . . . Lee, A. (2012). Infant feeding guidelines: information for health workers.

Blumer, H. (1986). *Symbolic interactionism: Perspective and method*: Univ of California Press.

Bridges, N., Howell, G., & Schmied, V. (2018). Exploring breastfeeding support on social media. *International Breastfeeding Journal, 13*, 9. doi:10.1186/s13006-018-0166-9.

Brodribb, W., Fallon, A. B., Hegney, D., & O'Brien, M. (2007). Identifying predictors of the reasons women give for choosing to breastfeed. *Journal of Human lactation*, *23*(4), 338-344. doi: 10.1177/0890334407307540.

Bunik, M., Shobe, P., O'Connor, M. E., Beaty, B., Langendoerfer, S., Crane, L., & Kempe, A. (2010). Are 2 weeks of daily breastfeeding support insufficient to overcome the influences of formula? *Academic Pediatrics, 10*(1), 21-28.

Burnard, P. (1991). A method of analyzing interview transcripts in qualitative research. *Nurse Education Today, 11*(6), 461-466. doi:https://doi.org/10.1016/0260-6917(91)90009-Y.

Burns, E., Schmied, V., Sheehan, A., & Fenwick, J. (2010). A meta-ethnographic synthesis of women's experience of breastfeeding. *Maternal & Child Nutrition, 6*(3), 201-219.

Burns, E., Schmied, V., Fenwick, J., & Sheehan, A. (2012). Liquid gold from the milk bar: Constructions of breastmilk and breastfeeding women in the language and practices of midwives. *Social Science & Medicine, 75*(10), 1737-1745. doi:10.1016/j.socscimed.2012.07.035

Burns, E., Fenwick, J., Sheehan, A., & Schmied, V. (2016). 'This little piranha': a qualitative analysis of the language used by health professionals and mothers to describe infant behaviour during breastfeeding. *Maternal & Child Nutrition, 12*(1), 111-124.

Burns, E., & Schmied, V. (2017). "The right help at the right time": Positive constructions of peer and professional support for breastfeeding. *Women and Birth, 30*(5), 389-397. doi:10.1016/j.wombi.2017.03.002.

Cadwell, K. (2007). Latching-On and Suckling of the Healthy Term Neonate: Breastfeeding Assessment. *Journal of Midwifery & Women's Health, 52*(6), 638-642. doi:https://doi.org/10.1016/j.jmwh.2007.08.004.

Cai, S., Pang, W. W., Low, Y. L., Sim, L. W., Sam, S. C., Bruntraeger, M. B.,… Richmond, J. (2014). Infant feeding effects on early neurocognitive development in Asian children.*The American Journal of Clinical Nutrition, 101*(2), 326-336. doi:10.3945/ajcn.114.095414

Cavalcanti, D. S., Cabral, C. S., de Toledo Vianna, R. P., & Osório, M. M. (2019). Online participatory intervention to promote and support exclusive breastfeeding: Randomized clinical trial. *Maternal & Child Nutrition, 15*(3), e12806.

Centers for Disease Control and Prevention (CDC). (2020). Breastfeeding report card—United States, 2020. *Retrieved December 2020*.

Centers for Disease Control and Prevention (CDC). (2018). Nutrition: Definitions. *Retrieved November 2018.*

Cernadas, J. M. C., Noceda, G., Barrera, L., Martinez, A. M., & Garsd, A. (2003). Maternal and perinatal factors influencing the duration of exclusive breastfeeding during the first 6 months of life. *Journal of Human Lactation, 19*(2), 136-144.

Charlick, S. J., McKellar, L., Gordon, A. L., & Pincombe, J. (2019). The private journey: An interpretative phenomenological analysis of exclusive breastfeeding. *Women and Birth, 32*(1), e34-e42.

Chung, M., Raman, G., Chew, P., Magula, N., Trikalinos, T., & Lau, J. (2007). Breastfeeding and maternal and infant health outcomes in developed countries. *Evidence Report/Technology Assessment No.153*, 1-186.

Cole, F. L. (1988). Content Analysis: Process and Application. *Clinical Nurse Specialist, 2*(1), 53-57.

Collaborative Group on Hormonal Factors in Breast Cancer (2002). Alcohol, tobacco and breast cancer–collaborative reanalysis of individual data from 53 epidemiological studies, including 58 515 women with breast cancer and 95 067 women without the disease. *British journal of cancer*, *87*(11), 1234-1245. doi: 10.1038/sj.bjc.6600596.

Conrad, P. (1992). Medicalization and social control. *Annual review of Sociology, 18*(1), 209-232.

Conrad, P. (2007). *The medicalization of society: On the transformation of human conditions into treatable disorders*: JHU Press.

Cowie, G. A., Hill, S., & Robinson, P. (2011). Using an online service for breastfeeding support: what mothers want to discuss. *Health Promotion Journal of Australia, 22*(2), 113-118

Creswell, J. W. (2012). Qualitative inquiry and research design: Choosing among five approaches. Los Angeles: Sage Publications.

Dennis, C.-L. (2002). Breastfeeding Initiation and Duration: A 1990-2000 Literature Review. *Journal of Obstetric, Gynecologic, & Neonatal Nursing, 31*(1), 12-32. doi:10.1111/j.1552-6909.2002.tb00019.x.

Dennis, C., Hodnett, E., Gallop, R., & Chalmers, B. (2002). The effect of peer support on breast-feeding duration among primiparous women: A randomized controlled trial. *Canadian Medical Association Journal, 166*(1)*,* 21-28.

Dermer, A., (2001). A well-kept secret breastfeeding's benefits to mothers. *New Beginnings,* 18(4) 124-127.

Dey I. (1993) Qualitative Data Analysis. A User-Friendly Guide for Social Scientists. Routledge, London.

Downe-Wamboldt, B. (1992). Content analysis: Method, applications, and issues. *Health Care for Women International, 13*(3), 313-321. doi:10.1080/07399339209516006.

Drentea, P., & Moren-Cross, J. L. (2005). Social capital and social support on the web: the case of an internet mother site. *Sociology of Health & Illness, 27*(7), 920-943. doi:10.1111/j.1467-9566.2005.00464.x.

Dykes, F., Moran, V. H., Burt, S., & Edwards, J. (2003). Adolescent mothers and breastfeeding: experiences and support needs—an exploratory study. *Journal of Human Lactation, 19*(4), 391-401.

Eidelman, A. I., Schanler, R. J., Johnston, M., Landers, S., Noble, L., Szucs, K., . . . Sect, B. (2012). Breastfeeding and the Use of Human Milk. *Pediatrics, 129*(3), E827-E841. doi:10.1542/peds.2011-3552.

Elo, S., & Kyngäs, H. (2008). The qualitative content analysis process. *Journal of Advanced Nursing, 62*(1), 107-115. doi:doi:10.1111/j.1365-2648.2007.04569.x.

Ericson, J., & Palmér, L. (2019). Mothers of preterm infants' experiences of breastfeeding support in the first 12 months after birth: a qualitative study. *Birth, 46*(1), 129-136.

Foster, S., Slade, P., & Wilson, K., (1996). Body image, maternal fetal attachment, and breast feeding. *Journal of Psychosomatic Research,* 41 (2), 181-184. doi: 10.1016/0022-3999(96)00035-9.

Flacking, R., & Dykes, F. (2013). 'Being in a womb' or 'playing musical chairs': the impact of place and space on infant feeding in NICUs. *Bmc Pregnancy and Childbirth, 13*, 11. doi:10.1186/1471-2393-13-179.

Froh, E. B., Cascino, A., Cerreta, S. K., Karsch, E. A., Kornberg, L. F., Lilley, J. E., . . . Spatz, D. L. (2018). Status of Legislative Efforts to Promote and Protect Breastfeeding and the Provision of Human Milk for Women Returning to Work in the First Postpartum Year. *Breastfeeding Medicine, 13*(7), 506-509.

Gibbs, B. G., & Forste, R. (2014). Breastfeeding, Parenting, and Early Cognitive Development. *The Journal of Pediatrics, 164*(3), 487-493. doi:https://doi.org/10.1016/j.jpeds.2013.10.015

Gibson, M. E. (2005). Getting back to basics - The curious history of breastfeeding in the United States. *American Journal of Nursing, 105*(10), 72C-72D.

Guttman, N. & Zimmerman, D. R. (2000). Low-income mothers' views on breastfeeding. *Social Science and Medicine, 50*(10), 1457-1473. doi: 10.1016/S0277-9536(99)00387-1.

Guay, A., Aunos, M., & Collin-Vézina, D. (2017). Mothering with an intellectual disability: A phenomenological exploration of making infant-feeding decisions. *Journal of Applied Research in Intellectual Disabilities, 30*(3), 511-520.

Guba, E. G., & Lincoln, Y. S. (1994). Competing paradigms in qualitative research. *Handbook of qualitative research, 2*(163-194), 105.

Hass, L. (2008). *Merleau-Ponty's philosophy*: Indiana University Press.

Hawkins, S. S., Griffiths, L. J., Law, C., & Millennium Cohort Study, C. (2007). Maternal employment and breast-feeding initiation: findings from the Millennium Cohort Study. *Paediatric and Perinatal Epidemiology, 21*(3), 242-247. doi:10.1111/j.1365-3016.2007.00812.x.

Heinig, M. J., Follett, J. R., Ishii, K. D., Kavanagh-Prochaska, K., Cohen, R., & Panchula, J. (2006). Barriers to compliance with infant-feeding recommendations among low-income women. *Journal of Human Lactation, 22*(1), 27-38.

Hill, P. D., & Humenick, S. S. (1996). Development of the H&H lactation scale. *Nursing Research, 45*(3), 136-140. doi:10.1097/00006199-199605000-00003.

Horta, B. L., & Victora, C. G. (2013). Long-term effects of breastfeeding. *Geneva: World Health Organization, 74*.

Horta, B. L., Loret De Mola, C., & Victora, C. G. (2015). Breastfeeding and intelligence: a systematic review and meta-analysis. *Acta paediatrica, 104*, 14-19.

Hounsome, L., & Dowling, S. (2018). 'The mum has to live with the decision much more than the dad'. Men's perceptions of their influence on breastfeeding decision making: A qualitative study. *International Breastfeeding Journal, 13*(3).

Hsieh, H.-F., & Shannon, S. E. (2005). Three Approaches to Qualitative Content Analysis. *Qualitative Health Research, 15*(9), 1277-1288. doi:10.1177/1049732305276687.

Ingram, J., & Johnson, D. (2004). A feasibility study of an intervention to enhance family support for breast feeding in a deprived area in Bristol, UK. *Midwifery, 20*(4), 367-379.

Johnston, M. L., & Esposito, N. (2007). Barriers and facilitators for breastfeeding among working women in the United States. *Jognn-Journal of Obstetric Gynecologic and Neonatal Nursing, 36*(1), 9-20. doi:10.1111/J.1552-6909.2006.00109.x.

Jordan, S. J., Na, R., Johnatty, S. E., Wise, L. A., Adami, H. O., Brinton, L. A., . . . Webb, P. M. (2017). Breastfeeding and Endometrial Cancer Risk An Analysis From the Epidemiology of Endometrial Cancer Consortium. *Obstetrics and Gynecology, 129*(6), 1059-1067. doi:10.1097/aog.0000000000002057.

Kimbro, R. T. (2006). On-the-job moms: Work and breastfeeding initiation and duration for a sample of low-income women. *Maternal and Child Health Journal, 10*(1), 19-26. doi:10.1007/s10995-005-0058-7.

Kong, S. K., & Lee, D. T. (2004). Factors influencing decision to breastfeed. *Journal of advanced nursing*, *46*(4), 369-379. doi: 10.1111/j.1365-2648.2004.03003.x.

Kotlow, L. A. (1999). Ankyloglossia (tongue-tie): a diagnostic and treatment quandary. *Quintessence Int, 30*(4), 259-262.

Kotlow, L. A. (2013). Diagnosing and Understanding the Maxillary Lip-tie (Superior Labial, the Maxillary Labial Frenum) as it Relates to Breastfeeding. *Journal of Human Lactation, 29*(4), 458-464. doi:10.1177/0890334413491325.

Kozhimannil, K. B., Jou, J., Gjerdingen, D. K., & McGovern, P. M. (2016). Access to Workplace Accommodations to Support Breastfeeding after Passage of the Affordable Care Act. *Women's Health Issues, 26*(1), 6-13. doi:https://doi.org/10.1016/j.whi.2015.08.002.

Lau, Y., Htun, T. P., Tam, W. S. W., & Klainin-Yobas, P. (2016). Efficacy of e-technologies in improving breastfeeding outcomes among perinatal women: a meta-analysis. *Maternal and Child Nutrition, 12*(3), 381-400. doi:10.1111/mcn.12202.

Lawrence, R. A. & Lawrence, R. M. *Breastfeeding: A Guide for the Medical Professional-Expert Consult*. Elsevier Health Sciences, 2010. Print.

Lebron, C. N., St. George, S. M., Eckembrecher, D. G., & Alvarez, L. M. (2020). "Am I doing this wrong?" Breastfeeding mothers' use of an online forum. *Maternal & Child Nutrition, 16*(1), N.PAG-N.PAG. doi:10.1111/mcn.12890.

Leeming, D., Marshall, J., & Locke, A. (2017). Understanding process and context in breastfeeding support interventions: The potential of qualitative research. *Maternal & Child Nutrition, 13*(4), e12407.

Li, R., Fridinger, F., & Grummer-Strawn, L. (2002). Public Perceptions on Breastfeeding Constraints. *Journal of Human Lactation, 18*(3), 227-235. doi:10.1177/089033440201800304.

Li, R. W., Rock, V. J., & Grummer-Strawn, L. (2007). Changes in public attitudes toward breastfeeding in the United States, 1999-2003. *Journal of the American Dietetic Association, 107*(1), 122-127. doi:10.1016/j.jada.2006.10.002.

Lincoln, Y. S., & Guba, E. G. (1986). But is it rigorous? Trustworthiness and authenticity in naturalistic evaluation. *New directions for program evaluation, 1986*(30), 73-84.

Lindberg, N., & Berglund, A. L. (2014). Mothers' experiences of feeding babies born with cleft lip and palate. *Scandinavian Journal of Caring Sciences, 28*(1), 66-73.

Lumbiganon, P., Martis, R., Laopaiboon, M., Festin, M. R., Ho, J. J., & Hakimi, M. (2016). Antenatal breastfeeding education for increasing breastfeeding duration. *Cochrane Database of Systematic Reviews*(12). doi:10.1002/14651858.CD006425.pub4.

Matthews, E. (2006). *Merleau-Ponty: A guide for the perplexed*: A&C Black.

McCann, M. F., Baydar, N., & Williams, R. L. (2007). Breastfeeding attitudes and reported problems in a national sample of WIC participants. *Journal of Human Lactation, 23*(4), 314-324. doi:10.1177/0890334407307882.

McFadden, A., Gavine, A., Renfrew, M. J., Wade, A., Buchanan, P., Taylor, J. L., . . . MacGillivray, S. (2017). Support for healthy breastfeeding mothers with healthy term babies. *Cochrane Database of Systematic Reviews*(2), 292. doi:10.1002/14651858.CD001141.pub5.

McInnes, R. J., & Chambers, J. A. (2008). Supporting breastfeeding mothers: qualitative synthesis. *Journal of Advanced Nursing, 62*(4), 407-427. doi:10.1111/j.1365-2648.2008.04618.x.

Merleau-Ponty, M. (1996). *Phenomenology of perception*: Motilal Banarsidass Publishe.

Merleau-Ponty, M. (2002). Selections from Phenomenology of perception. *Selected Readings in the Philosophy of Perception*, 15.

Mezirow, J. (1997). Transformative learning: Theory to practice. *New directions for adult and continuing education, 1997*(74), 5-12.

Moore, E. R. & Coty, M., (2006). Prenatal and postpartum focus groups with primiparas: Breastfeeding attitudes, support, barriers, self-efficacy, and intention. *Journal of Pediatric Health Care, 20*(1), 35-46. doi: 10.1016/j.pedhc.2005.08.007.

Mozingo, J. N., Davis, M. W., Droppleman, P. G., & Merideth, A. (2000). "It wasn't working": Womens experiences with short-term breastfeeding. *The American Journal of Maternal/Child Nursing, 25*(3), 120-126.

Musante, K., & DeWalt, B. R. (2010). *Participant observation: A guide for fieldworkers*: Rowman Altamira.

Nelson, A. M. (2006). A metasynthesis of qualitative breastfeeding studies. *Journal of Midwifery & Women's Health, 51*(2), e13-e20.

Newton, N. R., & Newton, M. (1950). Relation of the Let-Down Reflex to the Ability to Breast Feed. *Pediatrics, 5*(4), 726.

Niela-Vilen, H., Axelin, A., Melender, H. L., Loyttyniemi, E., & Salantera, S. (2016). Breastfeeding preterm infants - a randomized controlled trial of the effectiveness of an Internet-based peer-support group. *Journal of Advanced Nursing, 72*(10), 2495-2507. doi:10.1111/jan.12993.

O'Brien, M., Buikstra, E., & Hegney, D. (2008). The influence of psychological factors on breastfeeding duration. *Journal of Advanced Nursing, 63*(4), 397-408. doi: 10.1111/j.1365-2648.2008.04722.x.

Owen, C., Martin, R., Whincup, P., Smith, G., & Cooke, D., (2005). Effect on infant feeding on the risk of obesity across the life course: A quantitative review of published evidence. *Journal of the American Academy of Pediatrics,* 115 (5), 1367-1377. doi: 10.1542/peds.2004-1176.

Palmér, L., Carlsson, G., Brunt, D., & Nyström, M. (2015). Existential security is a necessary condition for continued breastfeeding despite severe initial difficulties: a lifeworld hermeneutical study. *International Breastfeeding Journal, 10*(1), 17.

Picciano, M. F. (2001). Nutrient composition of human milk. *Pediatric Clinics of North America, 48*(1), 53-67.

Polit, D. F., & Beck, C. T. (2013). *Study guide for essentials of nursing research: appraising evidence for nursing practice*: Lippincott Williams & Wilkins.

Powell, R., Davis, M., & Anderson, A. K. (2014). A qualitative look into mother's breastfeeding experiences. *Journal of Neonatal Nursing, 20*(6), 259-265.

Raisler, J. (2000). Against the odds: breastfeeding experiences of low income mothers. *Journal of Midwifery & Women's Health, 45*(3), 253-263.

Ratnasari, D., Paramashanti, B. A., Hadi, H., Yugistyowati, A., Astiti, D., & Nurhayati, E. (2017). Family support and exclusive breastfeeding among Yogyakarta mothers in employment. *Asia Pacific journal of clinical nutrition, 26*(Supplement), S31.

Regan, S., & Brown, A. (2019). Experiences of online breastfeeding support: Support and reassurance versus judgement and misinformation. *Maternal & Child Nutrition, 15*(4), e12874.

Rempel, L. A., & Rempel, J. K. (2004). Partner influence on health behavior decision-making: Increasing breastfeeding duration. *Journal of Social and Personal Relationships, 21*(1), 92-111. doi:10.1177/0265407504039841.

Rempel, L. A., & Rempel, J. K. (2011). The Breastfeeding Team: The Role of Involved Fathers in the Breastfeeding Family. *Journal of Human Lactation, 27*(2), 115-121. doi:10.1177/0890334410390045

Robson C. (1993) Real World Research. A Resource for Social Scientists and Practitioner–Researchers. Blackwell Publishers, Oxford.

Schmied, V., Beake, S., Sheehan, A., McCourt, C., & Dykes, F. (2011). Women's Perceptions and Experiences of Breastfeeding Support: A Metasynthesis. *Birth-Issues in Perinatal Care, 38*(1), 49-60. doi:10.1111/j.1523-536X.2010.00446.x.

Schmied, V., Olley, H., Burns, E., Duff, M., Dennis, C.-L., & Dahlen, H. G. (2012). Contradictions and conflict: A meta-ethnographic study of migrant women's experiences of breastfeeding in a new country. *Bmc Pregnancy and Childbirth, 12*(1), 163.

Schwarz, E. B., Ray, R. M., Stuebe, A. M., Allison, M. A., Ness, R. B., Freiberg, M. S., & Cauley, J. A. (2009). Duration of lactation and risk factors for maternal cardiovascular disease. *Obstetrics and gynecology, 113*(5), 974.

Sikorski, J., Renfrew, M. J., Pindoria, S., & Wade, A. (2003). Support for breastfeeding mothers: a systematic review. *Paediatric and Perinatal Epidemiology, 17*(4), 407-417. doi:10.1046/j.1365-3016.2003.00512.x.

Smith, J. A. (1996). Beyond the divide between cognition and discourse: Using interpretative phenomenological analysis in health psychology. *Psychology and health, 11*(2), 261-271.

Smith, J. A. (2004). Reflecting on the development of interpretative phenomenological analysis and its contribution to qualitative research in psychology. *Qualitative research in psychology, 1*(1), 39-54.

Sohn, B. K., Thomas, S. P., Greenberg, K. H., & Pollio, H. R. (2017). Hearing the voices of students and teachers: A phenomenological approach to educational research. *Qualitative Research in Education, 6*(2), 121-148.

Spencer, R. L., & Fraser, D. M. (2018). 'You're kinda passing a test': A phenomenological study of women's experiences of breastfeeding. *British Journal of Midwifery, 26*(11), 724-730.

Spencer, R. L., Greatrex-White, S., & Fraser, D. M. (2015). 'I thought it would keep them all quiet'. Women's experiences of breastfeeding as illusions of compliance: an interpretive phenomenological study. *Journal of Advanced Nursing, 71*(5), 1076-1086.

Spradley, J. P. (1980). Doing participant observation. *JP Spradley, Participant observation*, 53-84.

Stenov, V., Hempler, N. F., Reventlow, S., & Wind, G. (2018). An ethnographic investigation of healthcare providers' approaches to facilitating person-centredness in group-based diabetes education. *Scandinavian Journal of Caring Sciences, 32*(2), 783-792. doi:10.1111/scs.12509.

Stuebe, A. (2009). The Risks of Not Breastfeeding for Mothers and Infants. *Obstetrics & Gynecology,2*(4), 222-231.

Sulaiman, Z., Liamputtong, P., & Amir, L. H. (2016). The enablers and barriers to continue breast milk feeding in women returning to work. *Journal of Advanced Nursing, 72*(4), 825-835.

Taveras, E. M., Capra, A. M., Braveman, P. A., Jensvold, N. G., Escobar, G. J., & Lieu, T. A. (2003). Clinician support and psychosocial risk factors associated with breastfeeding discontinuation. *Pediatrics, 112*(1), 108-115.

Thulier, D., & Mercer, J. (2009). Variables associated with breastfeeding duration. *Journal of Obstetric, Gynecologic, & Neonatal Nursing, 38*(3), 259-268.

Tohotoa, J., Maycock, B., Hauck, Y. L., Howat, P., Burns, S., & Binns, C. W. (2009). Dads make a difference: an exploratory study of paternal support for breastfeeding in Perth, Western Australia. *International Breastfeeding Journal, 4*(1), 15.

Torres, J. M. C. (2014). Medicalizing to demedicalize: Lactation consultants and the (de)medicalization of breastfeeding. *Social Science & Medicine, 100*, 159-166. doi:https://doi.org/10.1016/j.socscimed.2013.11.013

Tuan, Y.-F. (1977). *Space and place: The perspective of experience*: U of Minnesota Press.

United Nations Children's Fund (UNICEF), World Health Organization. (2018). Capture the Moment–Early initiation of breastfeeding: The best start for every newborn. *New York: UNICEF*.

U.S. Bureau of Labor and Statistics (2017). Economic news release. *Access to and Use of Leave Summary*.

U.S. Department of Health and Human Services (2011). The Surgeon General's call to action to support breastfeeding. *Retrieved May 2020.*

U.S. Department of Health and Human Services (2013). Healthy people 2020: Maternal, Infant and Child Health. *Retrieved May 2020.*

U.S. Department of Health and Human Services (2018). Breastfeeding Rates: Breastfeeding Among U.S. Children Born 2010-2017, CDC National Immunization Survey. *Retrieved May 2020.*

Van Manen, M. (2016). *Researching lived experience: Human science for an action sensitive pedagogy*: Routledge.

Victora, C. G., Horta, B. L., De Mola, C. L., Quevedo, L., Pinheiro, R. T., Gigante, D. P., . . . Barros, F. C. (2015). Association between breastfeeding and intelligence, educational attainment, and income at 30 years of age: a prospective birth cohort study from Brazil. *The lancet global health, 3*(4), e199-e205.

Vogel, A., & Mitchell, E. (1998). The establishment and duration of breastfeeding: Part 1: Hospital influences. *Breastfeeding review, 6*(1), 5.

Wellard, S., & Hailes, J. (2000). Support for breastfeeding in the first postpartum month: perceptions of breastfeeding women. *Breastfeeding review, 8*(3), 5.

World Health Organization (2011). Exclusive breastfeeding for six months best for babies everywhere. *Retrieved May 2020.*

World Health Organization (2018). Breastfeeding. *Retrieved May 2020.*

Appendices

Appendix A

	Group Participation	Ethnographic Observations	Ethnographic Analysis	Phenomenology Interviews	Phenomenology Analysis	Member Checks
May-19						
Jun-19						
Jul-19						
Aug-19						
Sep-19						
Oct-19						
Nov-19						
Dec-19						
Jan-20						
Feb-20						
Mar-20						
Apr-20						
May-20						
Jun-20						
Jul-20						
Aug-20						
Sep-20						
Oct-20						

Figure 1. *Data and Analysis Timeline*

Appendix B

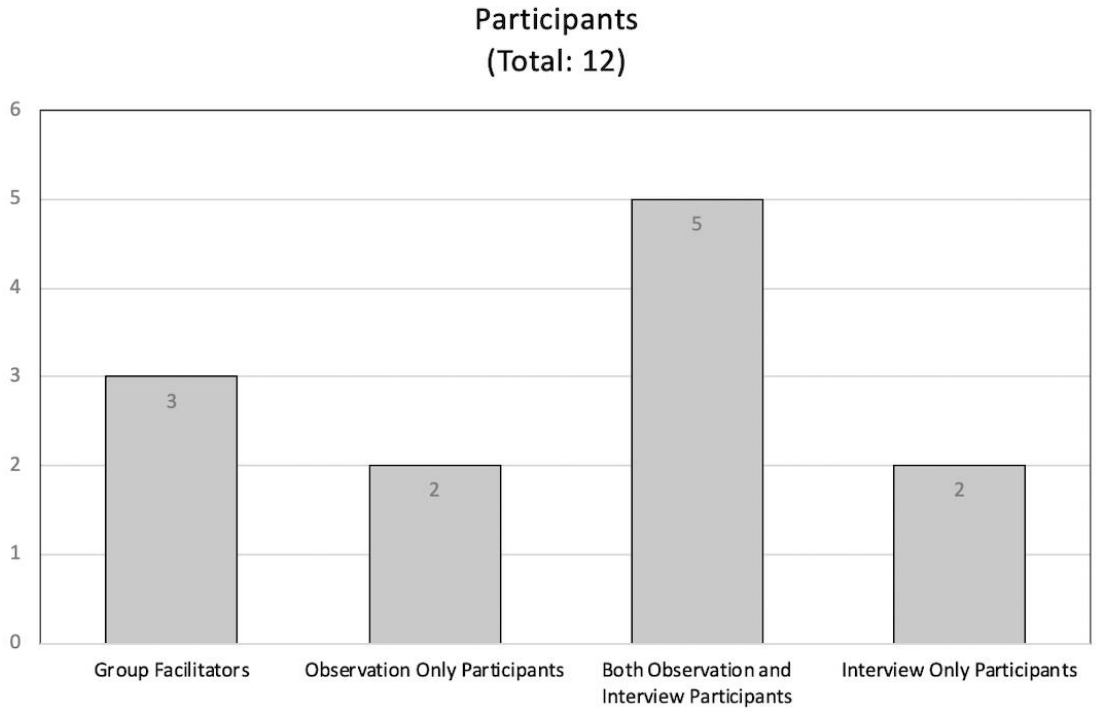

Figure 2. *Study Participants*

Appendix C

Demographic Forms

Facilitator Demographic Survey:

1. Date of birth:

2. Marital status:

3. Do you have any children? YES NO

    a. If yes, how many?

4. Have you ever breastfed an infant? YES NO

    a. If yes, how many?

    b. If yes, for how long?

5. What are your personal breastfeeding experiences? POSITIVE NEGATIVE

    a. Please explain

6. What degree(s) do you have?

7. Do you have any certifications? YES NO

    a. If yes, which certification(s) do you have?

8. What is your occupation?

    a. How long have you been at your current job?

    b. How many years of experience do you have in your field?

9. How long have you been working with the TLC support group?

10. How long have you provided support for breastfeeding mothers?

Group Member Demographic survey:

1. Date of birth of mother:
2. Date of birth of infant:
3. Gender of infant:
4. Number of children:
    a. If more than one child, how did you feed your other children?

5. Has your infant ever been breastfed? YES NO OTHER/COMBINATION
    a. If other/combination, please explain:

6. How are you currently feeding your infant? (additional prompts to clarify: exclusive breastfeeding, pumping, combination feeding, formula, complementary foods, etc.)

7. Was your infant FULL TERM PREMATURE POST-TERM
    a. If premature, how premature?

    b. If post-term, how much past your due date?

8. Did you attend any birthing classes? YES NO
    a. If yes, which ones and for how many sessions?

    b. If yes, was the class/classes required?

9. Did you attend any parenting classes during pregnancy? YES NO
    a. If yes, which one and for how long?

    b. If yes, was the class/classes required?

10. Did you attend any breastfeeding classes during pregnancy? YES NO
    a. If yes, which one and for how long?

    b. If yes, was the class/classes required?

11. How many people live in your household including yourself?
    a. How are they related to you?

b. Do they provide support for infant feeding? And if so, how?

12. What is your marital status?

a. Single

b. Dating

c. Cohabitating

d. Married

e. Divorced

f. Widowed

g. Other (please specify)

13. Are you married to the other parent of the infant?

14. Are you currently living with the other parent of the infant?

15. What is your highest level of education?

16. Are you currently working for pay?

a. If yes, what is your occupation?

b. If yes, have your working conditions (including type of job, hours, pay, etc.) changed since pregnancy through now?

c. Has your work environment influenced your decision and/or ability to make infant feeding choices?

17. Is the other parent of the infant working?

a. If yes, what is their occupation?

18. What is your current combined family income before taxes?

a. Below $10,000
b. Between $10,000 and $22,999
c. Between $23,000 and $35,999
d. Between $36,000 and $48,999
e. Between $49,000 and $51,999
f. Between $52,000 and $64,999
g. Between $65,000 and $77,999
h. Between $78,000 and $90,999
i. Above $91,000

Appendix D

Table 1. *Group Member's Demographic Chart*

Demographic Question	Participants								
	Participant 1: Rachel	Participant 2: Carly	Participant 3: Veda	Participant 4: Caitlin	Participant 5: Kaley	Participant 6: Lauren	Participant 7: Lisa	Participant 8: Anna	Participant 9: Angela
Mothers age	35	32	38	32	32	40	33	34	30
Infants age	12 months	11 months	17 months	11 months	13 months	10	21 months	7 months	17 months
Infant Gender	Male	Female	Male	Female	Male	Female	Female	Male	Male
Number of Children	1	1	1	1	1	1	1	1	1
Infant Feeding Practices	Breast milk, Formula, Complementary Foods	Breast milk	Breast milk and Formula	Breast milk	Breast milk, Formula, Complementary Foods	Breast milk, Formula, Complementary Foods	Breast milk and Complementary Foods	Breast milk	Breast milk and Complementary Foods
Gestation	Post-Term (40.4 weeks)	Premature (37 weeks)	Premature (37 weeks)	Post-Term (41.5 weeks)	Full Term	Post-Term (42 Weeks)	Full Term	Full term	Full Term
Birthing Class	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes
Parenting Class	No	No	Yes	Yes	No	Yes	Yes	No	Yes
Breastfeeding Class	Yes	No	No	Yes	Yes	No	Yes	No	Yes
Members of Household	3	3	3	3	2	3	3	3	3
Marital Status	Married	Married	Married	Married	Dating	Married	Married	Married	Married
Married to Infants Other Parent	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	No
Education Level	Masters Degree	Undergraduate Degree	Masters Degree	Masters Degree	Ph.D.	Masters Degree	Ph.D.	Associate Degree	Some College
Working for Pay	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Other Parent of Infant Working	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Combined Household Income	Above $91,000	Between $78,000 and $90,000	Between $65,000 and $77,999	Above $91,001	Above $91,000	Between $36,000 and $48,999	Above $91,000	Between $52,000 and $64,999	Beteween $49,000 and $51,999

Appendix E

Table 2. *Facilitator Demographic Table*

Demographic Question	Facilitators		
	Facilitator 1	Facilitator 2	Facilitator 3
Age	47	58	43
Marital Status	Married	Married	Married
Children	3	1	4
Ever Breastfed an Infant	Yes	Yes	Yes
Number of Children Breastfed	3	1	4
Duration of Breastfeeding	10-13 Months	~ 1 Year	2 + Years Each
Degree	Bachelors of Science in Nursing	Bachelors of Science in Nursing	Associates in Nursing / Bachelors in Human Lactation
Certifications	International Board Certified Lactation Consultant	International Board Certified Lactation Consultant / Certified Childbirth Educator	International Board Certified Lactation Consultant
Years at Current Job	4	12	4
Years Providing Breastfeeding Support	20	28	20
Time with the Current Support Group	2 Months	3 Years	4 years

Appendix F

Maternal Experience Interview questions:

1. Tell me about your experiences feeding your current infant.
2. Tell me about your experiences making infant feeding choices for your current infant.
3. Tell me about why you joined this support group.
    a. Clarifying prompt: what influenced your decision to join the support group?
4. Tell me about your experiences attending group meetings.
5. Tell me about your experiences interacting with other group members.
6. Tell me about your experiences interacting with group facilitators.

Appendix G

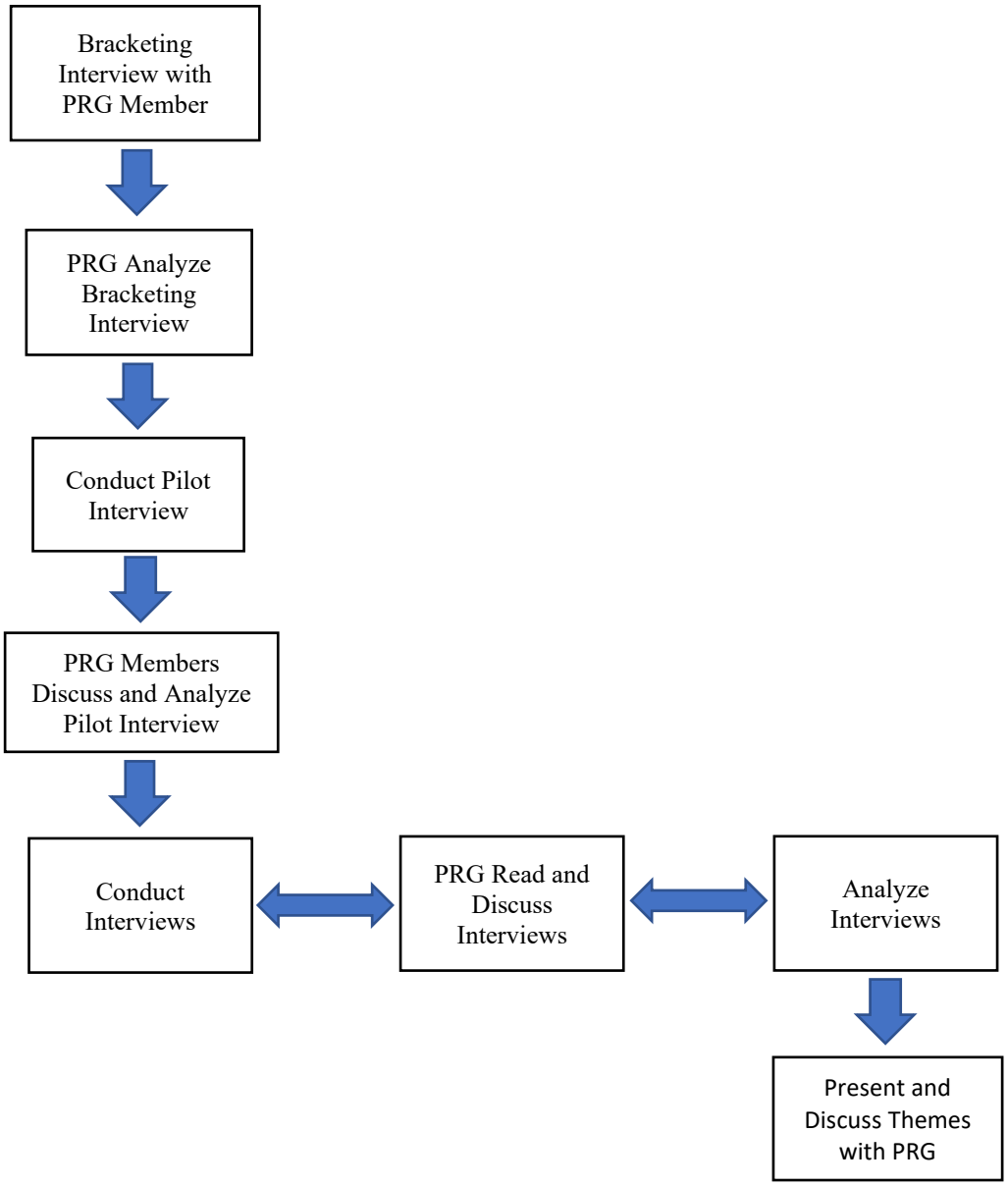

Figure 3. *Phenomenology Research Group (PRG) Procedures*

Appendix H

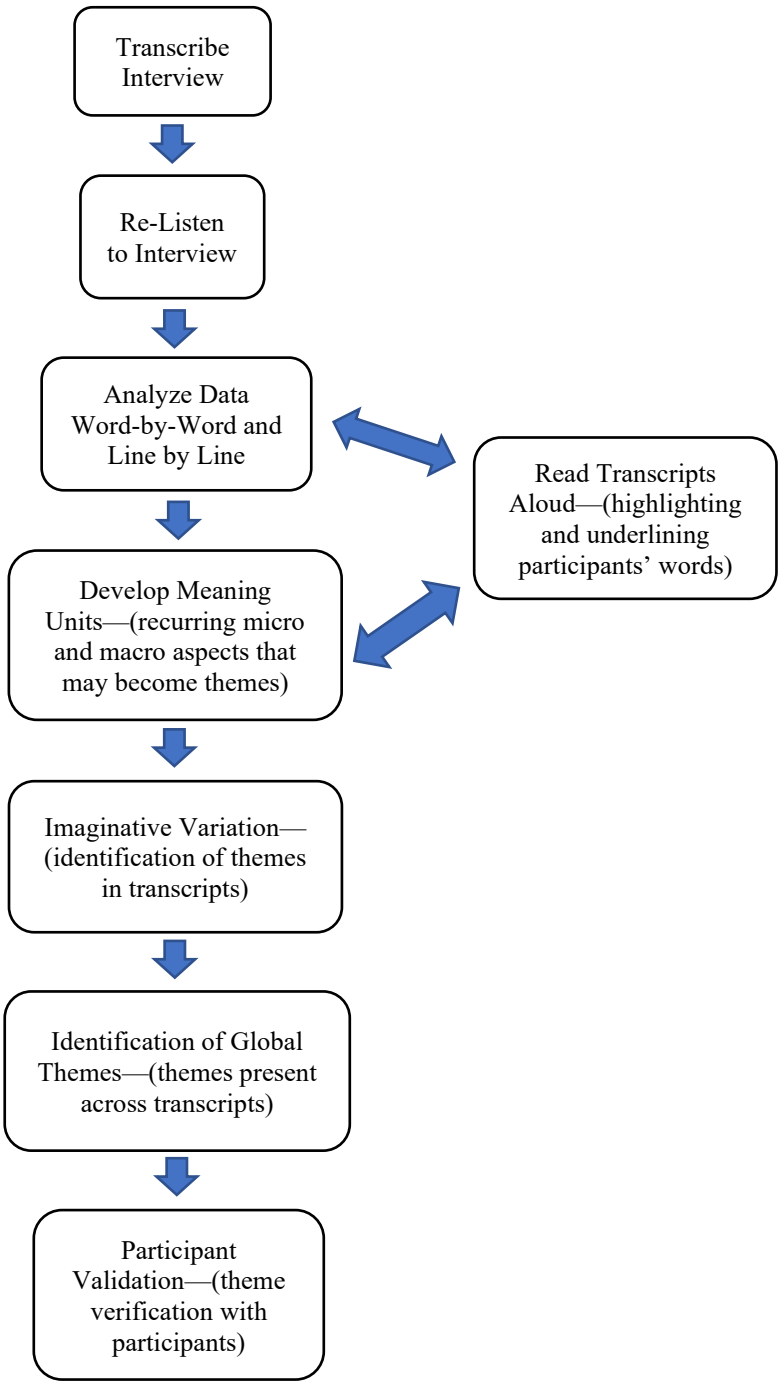

Figure 4. *Phenomenology Research Group (PRG) Analysis Procedures*

Appendix I

Global Themes and Subthemes

Theme 1: "*I didn't know*"	**Theme 2:** "*They helped*"	**Theme 3:** "*I wasn't alone*"	**Theme 4:** Pseudo-family
Subtheme 1: Is it enough	**Subtheme 1:** Physical Support	**Subtheme 1:** Connection	**Subtheme 1:** Sarah
Subtheme 2: Theory vs. Lived Experience	**Subtheme 2:** "*They remembered*"	**Subtheme 2:** Community	
Subtheme 3: Anxiety		**Subtheme 3:** Confidence	
Subtheme 4: Seeking help			

Figure 5. *Global Themes and Subthemes*

Appendix J

Room 1	Room 2	Room 3	Room 4
Basic set up: • Smaller rectangular room • No windows • Participants in a circle • Private space with closed door • Second level of building Walk in: Mothers immediately in front, scale to the right, and strollers/baby gear along the walls Variations: Sometimes the chairs and tables were set up in the circle position and other times the tables were pushed off to the side and mothers sat in a circle on the floor or in a circle with the chairs.	Basic set up: • Smaller rectangular room • No windows • Participants in chairs in a circle • Private space with closed door • Second level of building • Room on floor for babies Walk in: Mothers immediately in front, scale centered against back wall, and strollers/baby gear along the walls and next to moms Variations: This room was consistently set up the same way and was least used for group meetings.	Basic set up: • Large square room • Windows along left and back wall • Participants in circle • Private space with closed door • Second level of building next to room 1 • Room on floor for babies Walk in: Mothers immediately in front, scale to the right against wall, and strollers/baby gear next to moms Variations: Sometimes the chairs and tables were used to create the circle, other times the tables were pushed to the side and mothers were in a circle with the chairs	Basic set up: • Largest room, square shaped • Windows on the left wall • Participants in chairs in a circle • Private space with closed door • Room on floor for babies to play Walk in: Mothers immediately in front (backs facing you when you walk in), scale against back wall and matts on floor in the middle of circle for babies Variations: The space is one large room divided into two rooms and a small hall with removable panels. Sometimes the panels were plexiglass and other times the panels were solid. Privacy varied.

Figure 6. *Descriptions of the Rooms, smallest to largest*

Appendix K

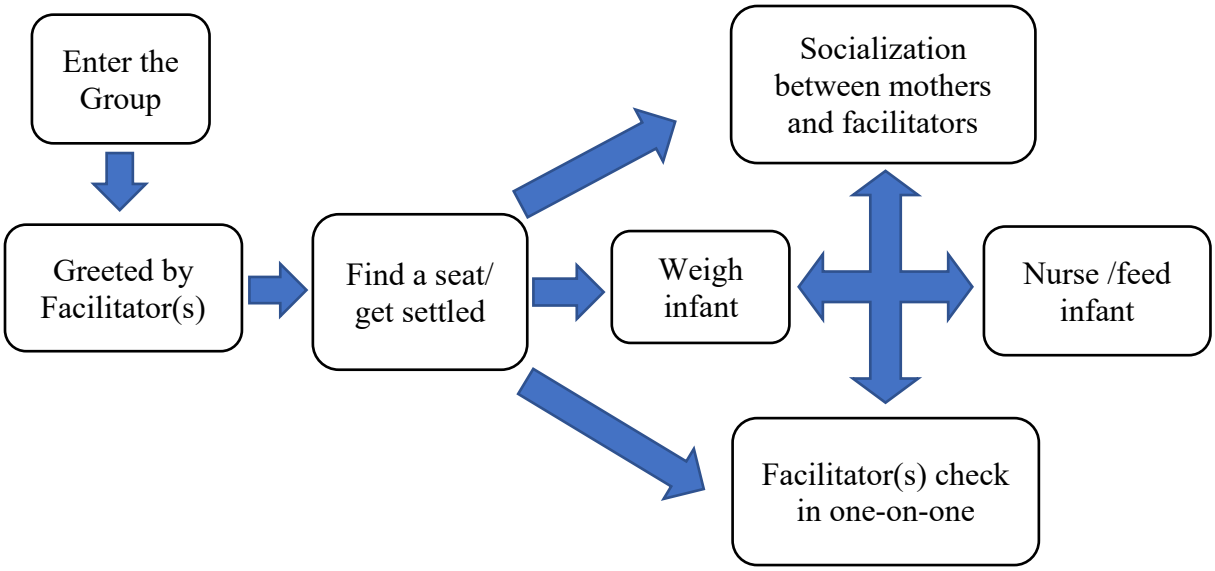

Figure 7. *Group Meetings Basic Events*

Appendix L

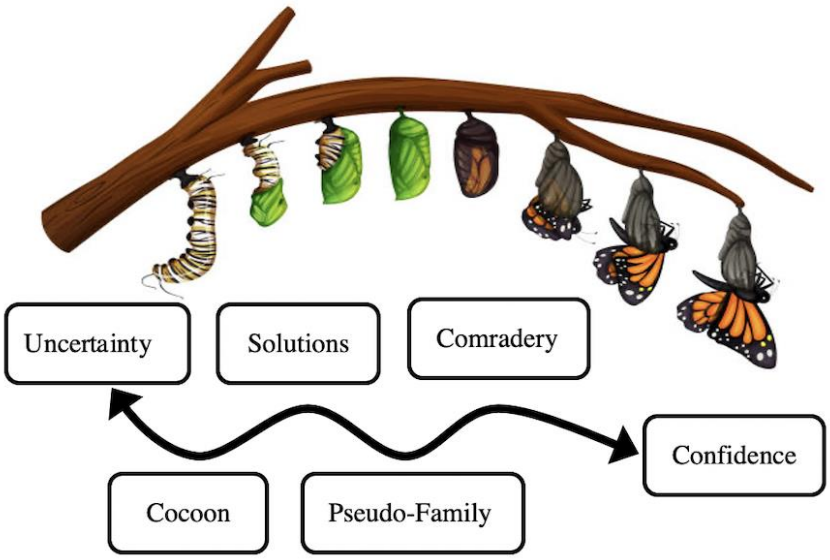

Figure 8. *Illustration of A Collective Metamorphosis*

Vita

Emily Alexandria Tucker is from Nashville, TN. She received her B.S. in Child and Family Studies, her B.A. in Africana Studies and her MS in Child and Family Studies all from the University of Tennessee Knoxville. Her co-major professors are Dr. Hillary Fouts and Dr. Madrid Akpovo. Alex's research focuses on prenatal physical activity and breastfeeding and infant feeding choices with an emphasis on maternal experiences and social-emotional needs.