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ARTICLE

Understanding the Relationship Between Breastfeeding-Related Pain and Mothering Using an Agency Framework

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Motherhood represents the fusion of mother and woman wherein a mothering identity becomes central. Motherhood is often based on romanticized and/or negative ideologies that are impacted by experiences of being a mother. Using agency as a framework, women's experiences of breastfeeding-related pain were explored in relation to context (iterational), thought patterns (projective), and decisions (evaluative). This case study, grounded in a feminist lens, we conducted in-depth interviews with 14 mothers (age range of 24 to 26 years) from an urban center in Southwestern Ontario, who had experienced breastfeeding-related pain. Using an agency framework, deductive thematic analysis was conducted resulting in the following themes: 1) iterational—which included peer groups, familiar experiences and societal pressures as the three main external forces that influenced a woman to breastfeed; 2) projective—women's perceptions and evaluation of their mothering abilities were impacted by their context of breastfeeding-related pain resulting in feelings of guilt and frustration; and 3) evaluative—the strategies mothers developed to continue or discontinue breastfeeding (such as tangible-nipple shields, latch support clinics, and creams or intangible-social support options) as well as acceptance of their decision. The impact of the context of breastfeeding within a paternalistic medical context and the implications for practice as well as suggestions for empowerment are explored.

I Introduction

Glenn, Chang and Forcey (2016) describe motherhood as the fusion of mother and woman wherein the mothering identity becomes central over the woman/person identity. During this fusion a woman's established identities shift to create a space for the new identity of motherhood, which becomes a central component of the woman's sense of self. The new motherhood identity is often based on ideologies predicated on a romanticized notion of what motherhood seemingly entails (Glenn, Chang, and Forcey 2016). Specifically, we see constructs such as lifegiving, self-sacrificing and lifelong commitment as common shared experiences amongst women when describing motherhood (Sutherland 2010; Benoit, Goldberg, and Campbell-Yeo 2016; Tummala-Narra 2009; Francis-Connolly 1998; Varcoe and Hartrick Doane 2007; Chodorow 1978; Francis-Connolly 2000). This romanticized idyllic notion of motherhood represents only part of the ideological mother construct, with the negative notion of motherhood rounding out the construct. The demonized side of mothering includes such notions as smothering, intrusiveness, and being overbearing (Glenn, Chang, and Forcey 2016; Tummala-Narra 2009). Together, both these facets – the romanticized and negative notion – intertwine to create the larger conception of motherhood.

This complex identity-construct of motherhood creates the underlying basis for how women classify their abilities as 'good' or 'bad'. These often dichotomous evaluations are an inherent part of motherhood (Sutherland 2010; Glenn, Chang, and Forcey 2016; Benoit, Goldberg, and Campbell-Yeo 2016). The result of using the lens of *good or bad* mothering is a competitive approach to motherhood (Leigh et al. 2012; Greaves et al. 2004; Fiske 1992). This competition associated with motherhood typically represents an internal comparison of the self to both other mothers and the idealization of what the woman's mothering abilities should entail. During this internal competition the classification of 'good' or 'bad' results in a cycle of self-talk that creates the overarching narrative for a woman in terms of her mothering abilities.

Motherhood is impacted further by the woman's social sphere. Motherhood ideologies are socially rather than biologically constructed, as being a mother is fundamentally linked to raising children as opposed to merely the act of giving

birth (Mercer 2004; Lothian 2008; Urwin et al. 2013). As a social construction, motherhood is therefore heavily impacted by, and a reflection of, the prevailing attitudes within a given culture. Within social circles, motherhood is impacted by the prevailing norms of peers which can include views about all facets of mothering (e.g. breastfeeding, child rearing practices, etc.) (Noll 2010; O'Mara and McKenna 2002; Andrews and Knaak 2013). Beyond the immediate social sphere, motherhood is impacted by the broader social context. In Canada, for example, the mother role is most often viewed as inferior to a job held outside of the home (Kirby 2005; Leigh et al. 2012). A mother in Canada then, might evaluate her own mothering abilities as *good* or *bad*, by considering the fusion of self (a woman's identity), the dueling motherhood ideologies (romanticized and negative) and the broader social context (Marshall, Godfrey, and Renfrew 2007; Sutherland 2010).

To fully understand motherhood, given the complexity and the interaction of the various components of the construct (i.e. self-identity, competition, and social construction) the concept of agency offers clarity. Agency affords the understanding how women create these self-assessments and how self-appraisals of good or bad mothering are formed within a personal and social context. Agency, according to the Chordal Triad of Agency, can be understood as 'the temporally constructed engagement by actors of different structural environments—the temporal-relational contexts of action—which, through the interplay of habit, imagination, and judgment, both reproduces and transforms those structures in interactive response to the problems posed by changing historical situations' (Emirbayer and Mische 1998, 970). This definition of agency is based on three interrelated constructs: 1) *iterational*—how history and context are incorporated into identities, interactions, and institutions over time; 2) *projective*—how thought patterns and future trajectories are creatively configured in relation to hopes, fears, and desires for the future; and 3) *evaluative*—practical judgments based on the previous two constructs in the presence of evolving situations and emerging demands, dilemmas and ambiguities (Emirbayer and Mische 1998). Specifically, this understanding of agency frames a woman's identity as being based on the integration of historical experiences and future desires, which creates an evaluative process wherein an individual makes judgments about capacities,

contexts, and desired outcomes. Using agency to understand motherhood helps to disentangle the complexities of the factors that are involved in the decisions related to mothering.

A decision central to motherhood is choosing whether or not to breastfeed. In Canada, there has been progressive movement toward promoting and supporting a breastfeeding culture. For example, the Baby-Friendly Hospital Initiative (BFHI) introduced by the World Health Organization (WHO) and United Nations Children's Fund (UNICEF) in 1991 has led to the implementation of BFHI programs, and accreditation within both hospital and community-based organizations. Since its inception, numerous countries across the globe, including Canada, have seen measurable improvements in exclusive breastfeeding (World Health Organization 2013, 2014). Since the research evidence overwhelmingly supports the benefits of breastfeeding and the notion that 'breast is best' (World Health Organization 2014) a 'hierarchy' of infant feeding practices has been established which places exclusive breastfeeding at very top of infant feeding options. Unfortunately, embedded in this hierarchy is a judgement and stigma against other types of infant feeding, such as formula feeding or combination (formula and breastmilk) feeding. As a result, for women who cannot breastfeed or choose to not breastfeed, 'breast is best', when practiced non-rationally or inappropriately, contributes to mothers feelings of shame and guilt (Thomson, Ebisch-Burton, and Flacking 2015; Taylor and Wallace 2012; Benoit, Goldberg, and Campbell-Yeo 2016). For instance, if only medical evidence is used in promoting the 'breast is best' campaign this creates a paternalistic context that negates a woman's ability to choose what is best for not only her infant but also herself (Wolf et al. 2007; Benoit, Goldberg, and Campbell-Yeo 2016). It is this power that health care professionals can create that is a paternalistic and 'normative' approach to maternal behavior which can be detrimental to mothers, especially if this contributes to their self-appraisal as being bad mothers (Hausman 2013; Hausman, Smith, and Lobbok 2012; Benoit, Goldberg, and Campbell-Yeo 2016). Unfortunately, there are examples where this paternalistic approach to 'breast is best' exist.

Despite the strong public promotion of breastfeeding and the subsequent escalation of breastfeeding initiation rates over the past few decades, worldwide, most North American women wean their infants well before the recommended 6 to 12 months postpartum (Dennis 2002). While multifactorial and complex, a women's decision to stop breastfeeding is not usually made by choice, but because of difficulties overcoming obstacles in her breastfeeding experience (Dennis 2002). Breastfeeding-related pain is one such obstacle, and is experienced by up to 77% to 96% of breastfeeding women (Head and Higgins 1995; Ziemer et al. 1990). Breastfeeding pain is cited as an important contributor to women's decision to stop breastfeeding prematurely (NHS Information Centre 2012; Cooke, Sheehan, and Schmied 2003). For women who choose to breastfeed and then experience breastfeeding-related pain, the decision to continue breastfeeding may require serious consideration and re-evaluation. The notion of breastfeeding as a 'natural' phenomenon has become synonymous with the impression that it is painless. However, research into breastfeeding-related pain and the impact on mothering and the decision to continue or stop breastfeeding is limited within the Canadian context. The purpose of this study is to gain insight into how breastfeeding-related pain impacts perceptions of motherhood using agency as the theoretical framework.

II Methods

The purpose of this study was to examine how agency informs our understanding of mothering through women's interpretation of breastfeeding-related pain. Using a feminist lens, this case study employed a deductive analytic approach to examine the relationship between agency, mothering, and breastfeeding-related pain (McIntyre and Lykes 2004; Halley et al. 2015; Hsieh and Shannon 2005; Dougherty 2005). This study also used a critical lens to identify and challenge patriarchal influences on the understanding of the relationship between breastfeeding-related pain and the women's conceptualization of being a mother. Moreover, attention was given to how women view motherhood, and how it is informed by context and gendered life experiences.

Recruitment and Data Collection

This Women's Xchange funded project was approved by the University of Western Ontario Research Ethics Board. A community-based sample of 14 women were recruited using posters and study champions from the local health unit through both convenience and snowball sampling. The inclusion criteria were English-speaking postpartum women: 1) aged 18 years of age or older; 2) that had delivered their infant within the past 12 months; and 3) had experienced breastfeeding-related pain in the past 2 months. The women in this study ranged from 25 to 36 ($M = 29.7$) years of age with infants ranging from 2 to 49 weeks ($M = 15.8$). Participants all identified as female and were primarily Caucasian (85.7%, $n = 12$). All women had post-secondary education, an average household income greater than \$50,000 (Canadian) annually, and lived in Southwestern Ontario, Canada (an urban setting). Participants who were interested in the study were asked to contact the Registered Nurse/Research Assistant (RA) using study phone. All participants who were eligible to participate in the study participated.

Each eligible participant enrolled in the study engaged in one 60 to 90-minute in-depth one-on-one interviews with a masters prepared RA at a mutually convenient time and private community location (such as a public library meeting room). Prior to the interviews being conducted informed written consent was obtained. The interviews were audio recorded and subsequently transcribed verbatim, and women were provided a \$20 honorarium in recognition of their time contribution to the study (at the outset of the interview). During and after the interviews the RA captured field notes that included any contextualizing information about the feel and experience of the interview (for example, participant body language, engagement, and mood). During the interview process data trustworthiness steps such as member checking, summarizing, and reflection were used to ensure the data collected were an accurate reflection of the woman's experience (Graneheim and Lundman 2004; Lincoln and Guba 2000; Hsieh and Shannon 2005). Recruitment stopped at a study sample of 14 women as it was determined that saturation was met, wherein no new themes were emerging.

Measures

For the interviews a semi-structured interview guide was used that included questions relating to mothering and breastfeeding. Questions related to the mother's decision to breastfeed included: 1) Can you describe how and when you decided to breastfeed?; 2) As a mother, how important is it for you to breastfeed your baby?; and 3) With respect to your family and/or your culture, how important is it for you to breastfeed your baby?. Next, women were asked questions related to breastfeeding-related pain including: 1) Can you tell me about when and how your breastfeeding-related pain started?, and 2) How did this pain affect how you were able to breastfeed?. Lastly, questions were asked about the relationship between mothering and pain including: 1) Can you tell me about how this experience of painful breastfeeding may or may not have affected your thoughts and feelings about being a mother?; 2) Can you describe how your experience with breastfeeding-related pain may have impacted the relationship you have with your baby in any way?; and 3) Can you describe how your gender may have played a part in your experience of breastfeeding-related pain?. During the interview the RA used probes (e.g., Can you tell me more?) to gain deeper insight into the woman's narratives.

Analysis Approach

Our deductive thematic analysis approach was adapted from Dougherty's work (Dougherty 2005). Specifically, data were transcribed verbatim and added, along with the field notes, to NVivo(Ltd., n.d.). Next, each researcher (TM and KTJ) became immersed in the data, carefully identifying and bracketing preconceived beliefs and opinions about the relationship between mothering and breastfeeding-related pain (Lewis, 2003). During this process the researchers kept extensive analysis notes describing encountered biases. These biases included personal feelings of adequacy and inadequacy in relation to mothering, experiences of breastfeeding and breastfeeding-related pain, and any judgment (good and/or bad) on decisions to breastfeed and the duration of breastfeeding. Once the researchers were immersed in the data, and we felt we had reached saturation in bracketing, we began selective cod-

ing related to judgments on mothering, agency (iterational, projective and evaluative), and breastfeeding-related pain (Hsieh and Shannon 2005). Initially, three categories of codes (i.e. mothering, agency, and breastfeeding-related pain) were used separately and then in relation to one another using axial coding. This process was completed in two phases; the first phase consisted of analyzing the first seven interviews that were completed, and the second phase was the second seven interviews. This group-to-group comparison approach was undertaken to ensure participants from each group expressed similar experiences (Morgan 1997).

III Results

The analysis revealed the relationship between iterational, projective, and evaluative beliefs to both the experience of breastfeeding-related pain and a woman's perception of mothering. **Figure 1** illustrates the interplay between mothering, and breastfeeding-related pain using agency. Each of these themes will be discussed in turn.

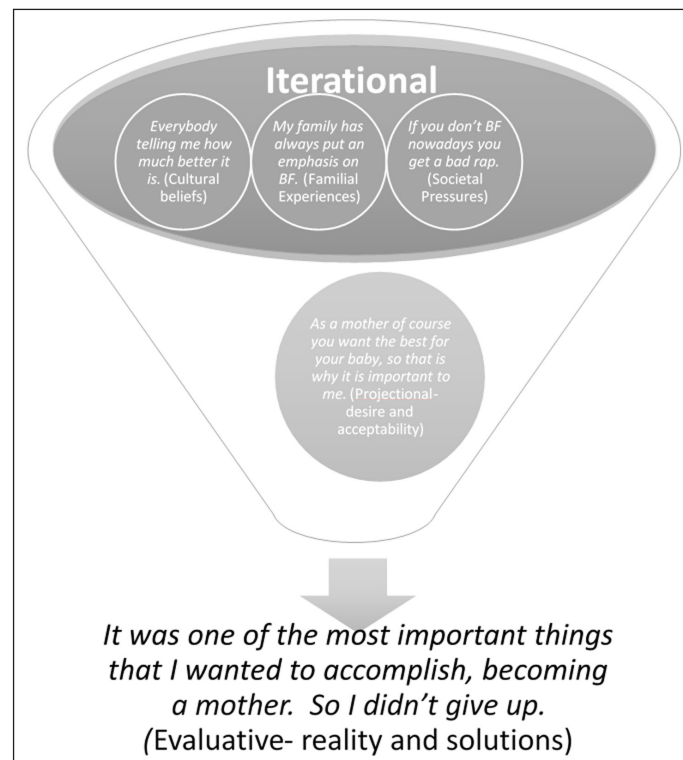


Figure 1: The Interplay between Mothering, and Breastfeeding-Related Pain Using Agency as a Framework.

Iterational

The majority of women in this study were influenced to breastfeed by three main external forces: peer groups, familial experiences, and societal pressures. Each of these influences created a context of societal pressure to *measure up*, deriving from society's expectation of breastfeeding. From peer groups, women discussed how within their immediate social circles breastfeeding was the expected and common experience and its importance was often emphasized. One woman highlighted this experience by saying, 'mostly, like, family and friends. Just everybody around me telling me how much better it is. So, I kind of felt pressured, obviously that way, to do it' (P 13). This peer pressure was amplified in familial experiences where traditions created the expectation to breastfeed. One woman described the decision to breastfeed as being almost automatic, as it was just something her family did, 'my family has put an emphasis on breastfeeding. It's just been that's what we do after we have babies – is you breastfeed' (P 3). This experience was echoed by many of the women, with another woman talking about how it was the norm in her family and how breastfeeding was an expectation, and not a decision to be made; 'my mom always breastfed myself and all my siblings, and I was the oldest and grew up in a large family and it was just normal. It was what you did' (P 17). In addition to peer and familial pressure there is a societal pressure in Canada to breastfeed, perhaps in part driven by the *BFHI* campaign. One woman felt that the decision to breastfeed or not would impact others' perceptions of her as a mother; 'I feel like if you don't breastfeed almost you get a bad rap for it' (P 1). The ramifications of not abiding by the 'breast is best' norm was felt by many of the women in the study. One woman went so far as to hide the fact she had started to supplement with formula, to avoid judgment. This woman described a conversation she had with a friend wherein she felt embarrassed of her decision to supplement because of the immense pressure put on her to breastfeed by society, and how it (breastfeeding) was viewed as the *right* choice.

You're my friend, and I care about you. But there's other things you can do besides formula.' But I didn't tell her I was using formula 'cause I felt that was my pro-choice and I felt hesitant to do that (P 16).

Projective

Women's perceptions and evaluation of their mothering abilities were impacted, for a majority of women, by the iterational influences of peer, familial, and societal influences and then contextualized by their experiences of pain. Given the woman's own concerns, and in addition to the pressure to breastfeed regardless of the pain, the trajectory for her future desires were often dictated by feelings of guilt and inadequacy. One woman described the difficulty of the position she was in and the impact that it had on her for even considering switching to formula because of the breastfeeding-related pain.

But I definitely had been taught that breastfeeding and the breast milk is best for your baby. So, I was in a position where, you know, I felt bad even considering that I was going to be switching to formula and giving my baby something that I had always not been so interested in giving her. But I was also quite uncomfortable with myself. So, it was deciding between my own discomfort and what I wanted to give my baby. So, it was a feeling of guilt as well (P 3).

For other women the connection between breastfeeding, breastfeeding-related pain and how they perceived themselves as mothers was even more direct. Many of the women in this study connected breastfeeding with being a *good* mother prior to having children. One woman highlighted this by saying, 'I kind of have always associated being able to breastfeed your baby successfully with being a good mom' (P 2). For the women in this study, the experience of breastfeeding-related pain often contradicted their previous understanding of being a *good* mother, which led to frustration, sadness, and a profound sense of failure. One woman talked about the tears she shed over the pain she felt and how she interpreted her pain and subsequent frustration as meaning she was a *bad* mother, 'I sat there and cried, and I felt like a terrible mother for getting mad at him, because it's not his fault, right. Like, he doesn't know he's doing anything wrong. He's just trying to get his food' (P 9). Another woman discussed the frustration she felt at her newborn because of the pain, and then the

failure she felt as a mother because of her frustration; 'Because I would get frustrated with him and the situation, then I would feel like, oh, I'm, like, probably the worst mom. What mom gets frustrated with their newborn baby. Because their baby isn't feeding right. Like, they're learning to, right (P 4)'.

Evaluative

The sum of the peer, familial, and societal pressures, along with the marked change in the trajectories of future desires faced by mothers experiencing breastfeeding-related pain required the mothers to develop ways in which they could continue or not to breastfeed through the pain: an evaluation of options. Most women sought support from numerous tangible (i.e. nipple shields, breastfeeding support clinics, and creams) as well as all women used intangible (i.e. social support from partners and other mothers) options. Ultimately, regardless of the solutions the women were engaging with to help them continue breastfeeding or not, and deal with the pain, most women needed to evaluate the pain and strategies used to come to terms with their feelings regarding breastfeeding-related pain. One woman viewed her triumph and ability to persevere through the pain as an indication of her being a *good* mother, stating, 'it was probably one of the most important things that I wanted to accomplish, becoming a mother. So, I didn't give up (P 9)'. Another woman felt that there was the expectation that, as a mother, she should sacrifice herself for her children, and for her, overcoming the breastfeeding pain embodied part of that sacrifice, 'yeah, you're supposed to make sacrifices for your kids, so I guess that's just one of the things that comes along with it' (P 11). However, the need to overcome the breastfeeding-related pain and sacrifice for their children to be a *good* mother was not the only narrative that emerged. Women also expressed the empowerment they felt having overcome the pain and how it contributed to their feelings of pride for being a *good* mother. This was highlighted when one woman said,

It's empowering, I think. Yeah, and it's something that as a woman you can give your baby that no one else really can, right. Like, my husband can't do that, and it's kind of the only thing that I can provide for him. So, it was important to my identity as a woman that I could do that for him (P 7).

Other women discussed how breastfeeding through the pain made them feel like better women:

You know, it sounds weird, this is going to sound weird, but to me the pain meant that, at the end of the day, I feel like a better mom for going through it, if that sounds strange. Like, I feel like I've gone through stuff to do everything I can to make him the healthiest as possible. And it at the end of the day makes me feel like a really good mum because I've overcome all of these obstacles. I don't know, might sound weird, but—yeah (P 9).

Despite the narratives of empowerment and success, the iterative influences were apparent,

I kind of have always associated being able to breastfeed your baby successfully with being a good mom. Like, I know that there's a lot of happy formula-fed babies out there. But that I wouldn't be as good a mom that I kind of wanted to be (P 3).

Interestingly, in our sample of women only one woman stopped breastfeeding because of the pain and she talked about the pressure she felt in her journey to deal with the pain saying, 'but [health care providers] were super supportive, but they just – after, like, eight visits they were out of ideas which I didn't expect. So, I cried then when they told me "we don't know what's wrong with you"' (P 6). This woman talked about the grief she experienced when she ran out of options to overcome the pain and how having practitioners give up on her felt despite her efforts to continue, 'And you just break down, right, and my husband would be, like, "what do I do? Why are you crying?" I'm, like, "it's nothing; I'm fine. It just hurts"' (P 6). Eventually, this woman decided to stop breastfeeding and not only gave her self-permission to do so and be a *good* mother but also talked about needing to remove the judgement and pressure on others who make similar decisions,

I guess we learn not to judge people and impose guilt or whatever. So, I have no guilt because I know I did the best I could and gave her a good start and now we're on formula. And she's a healthy girl so—yeah (P 6).

IV Discussion

This case study explored the impact of breastfeeding pain on a women's agency and conceptualization of mothering finding that the iterational context in Canada composed of peer, familial, and societal pressures ('breast is best') which creates a context where the decision to breastfeed is largely viewed as not a choice but rather a norm that informs whether you are a 'good' mother. The projective impact of the pressure within the iterational context created feelings of guilt and inadequacy when breastfeeding related-pain was experienced as mothers attributing pain to their notions of being 'bad' mothers. The evaluative impact of the combine iterational and projective context for women was the need to find resources to overcome the breastfeeding-related pain. Many women in this study overcame the breastfeeding related-pain to go on continuing breastfeeding which resulted in feelings of triumph and success. For one woman who decided to stop breastfeeding because of the breastfeeding-related pain this resulted in a re-framing of her understanding of being a 'good' mother.

Understanding the impact of breastfeeding-related pain on women's sense of agency and how women view their mothering abilities (i.e. 'good' and 'bad') is important, as often the decision to breastfeed and the ensuing experience is one of the first decisions made as a mother (Benoit, Goldberg, and Campbell-Yeo 2016). Breastfeeding therefore, offers the first time the romanticized notions of being a mother are confronted with the reality of negative notions (i.e. breastfeeding related-pain). This study provides foundation work in understanding how the breastfeeding related-pain impacts a mother's agency and how mothers work through their decision to breastfeed.

The major emerging theme of medical paternalism and the associated impact on women are not new. Burns and colleagues (2013) recommended clinicians, when providing care, must not prioritize optimal infant nutrition above the psychological needs of mother. The importance of removing paternalistic oppression from breastfeeding and replacing it with choice is underscored as a foundational component to remove maternal guilt associated with not breastfeeding which was a common theme that emerges both in the literature as well as within this study (Hausman,

Smith, and Lobbok 2012). However, the enactment of this recommendation and similar recommendations by others such as ensuring versions of the 'breast is best' campaign are implemented within the context of the lived experience of the woman have largely been ignored (Benoit, Goldberg, and Campbell-Yeo 2016; Baker Miller and Richards 2000; Cooke, Sheehan, and Schmied 2003).

An important finding of this study was the impact of breastfeeding-related pain on breastfeeding decision making and the ensuing impact on mothering. To date, public health has largely veered away from telling women of the potential of breastfeeding-related pain due in large part to the fact that it contravenes the 'breast is best' discourse and out of fear that telling women it could hurt might result in their unwillingness to breastfeed (Murphy 1999; Akre 2010). This paternalistic practice and policy-based approach demonstrates another way in which a woman's agency and ability to choose is being removed (Sherwin 1992b; Benoit, Goldberg, and Campbell-Yeo 2016). It has been suggested that anticipatory guidance related to breastfeeding-related pain could offer one such mechanism to educate and inform women in terms of the existence of breastfeeding-related pain and potential strategies that could support their desire to breastfeed or not (Tanski et al. 2010; Greenberg and Smith 1991).

The findings of this study also shine a light on the emotional impact of policies on breastfeeding practices. While breastfeeding is the optimal source of nutrition for infants, (Cutting 1995; Collaborative Group on Hormonal Factors in Breast Cancer 2002; World Health Organization 2014), understanding the personal nature of this decision is important when framing policies (Brown, Raynor, and Lee 2011). Policies that present a singular option in relation to breastfeeding are implemented without consideration for a woman's lived experience. For instance, a breastfeeding review by Akre (2010) highlighted an overarching goal in the breastfeeding support community to replacing 'the benefits of breastfeeding' with 'the risks of not breastfeeding' when engaging stakeholder (i.e. mothers, practitioners, health care providers, etc.). While in theory the goal of this change was to overcome misinformation about breastfeeding that is widely accessible, in reality this is an oppressive and paternalistic approach to health care wherein the woman is not valued as a partner or equal in the decision making process (Benoit,

Goldberg, and Campbell-Yeo 2016; Sherwin 1992a). While breastfeeding policies are at their core designed to provide infants with the best possible start, when they are implemented negating a woman's lived experience they create an experience of judgement, and therefore at their core are not a reflection of health promotion (the process of enabling people to increase control over and improve their health) (Burns et al. 2013; Schmied and Barclay 1999).

Understanding the contributions of these study findings must be considered within the methodological limitations of the research. The sample of women represented in this study were largely a homogenous group of partnered, educated, Caucasian women. As such, their experiences might not be representative of the broader Canadian culture. Future studies should look at gaining an understanding of experiences of breastfeeding-related pain in a more diverse/representative sample. In addition, mothers in this study were educationally and economically advantaged, and may have had increased knowledge and/or access to resources than other less privileged women in relation to supports and services for breastfeeding. Also, given that only one mother stopped breastfeeding, her experiences of breastfeeding related-pain on mother and agency must be understood as unique and may not be representative of a larger sample. Future studies should ensure a larger more diverse sample (with equal representation of mothers who continued and stopped breastfeeding because the breastfeeding related-pain) is included to ensure the diversity of the Canadian context can be observed. This is especially important, given that only half of breastfeeding Canadian women breastfeed exclusively beyond 3 months after birth (Public Health Agency of Canada, 2009). Despite the limitations of this study, this study offers important contributions in relation to the understanding of mothering, agency, and breastfeeding-related pain and area of research that is still largely emerging.

Conclusion

Supporting women to overcome breastfeeding-related pain has important implications for empowering women. Understanding the complex interplay of agency, mothering, and breastfeeding related-pain not only affords insight into how to better support mothers to deal with breastfeeding related-pain but also how to support

and empower mothers given the context of competition. Mothering is a time that is met with a mix of emotions and normalizing this experience through the continued dialogue with individuals who interact with mothers offers one such avenue to better empower mothers throughout their journey. Motherhood has become intertwined with an inherent sense of judgement by both the mother herself as well as others and ensuring campaigns, policies and training are put in place with the core goal ensuring an end to paternalistic approaches to care in favor of a truly woman centered approach offers one such avenue to ensure empowerment of mothers moving forward.

Competing Interests

The authors have no competing interests to declare.

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