CE **1.5 ANCC Contact Hours**

Abstract

Purpose: Breastfeeding-related pain is commonly experienced early in the postpartum period and is an important contributor to breastfeeding cessation, yet little is known about what this pain means to women and how it is experienced. The purpose of this study was to gain a better understanding of the phenomenon of breastfeeding-related pain, how women experience this pain, and the meaning it holds for them.

Study Design and Methods: Interpretive descriptive methods and inductive content analysis were used. Women were recruited using purposive sampling with a snowball approach. Data were collected via one-to-one interviews using a semistructured interview guide with postpartum women having experienced breastfeeding-related pain in the past 2 months.

Results: Fourteen postpartum women who met inclusion criteria were interviewed. They were predominantly Caucasian, well educated, and had greater than average Canadian annual household incomes. The dominant emerging discourse revealed three key themes: (a) interplay between breastfeeding pain and context, (b) action enablers and/or barriers, and (c) breastfeeding outcomes.

Clinical Implications: Breastfeeding-related pain is an unpleasant sensory and affective experience for women during the postpartum period. Availability and accessibility of breastfeeding supports are essential to enable women to achieve their breastfeeding goals. Providing anticipatory guidance may help women to cope more effectively with their breastfeeding-related pain.

Key words: Breastfeeding; Pain; Postpartum; Qualitative research.

Women's Experiences of Breastfeeding-Related Pain

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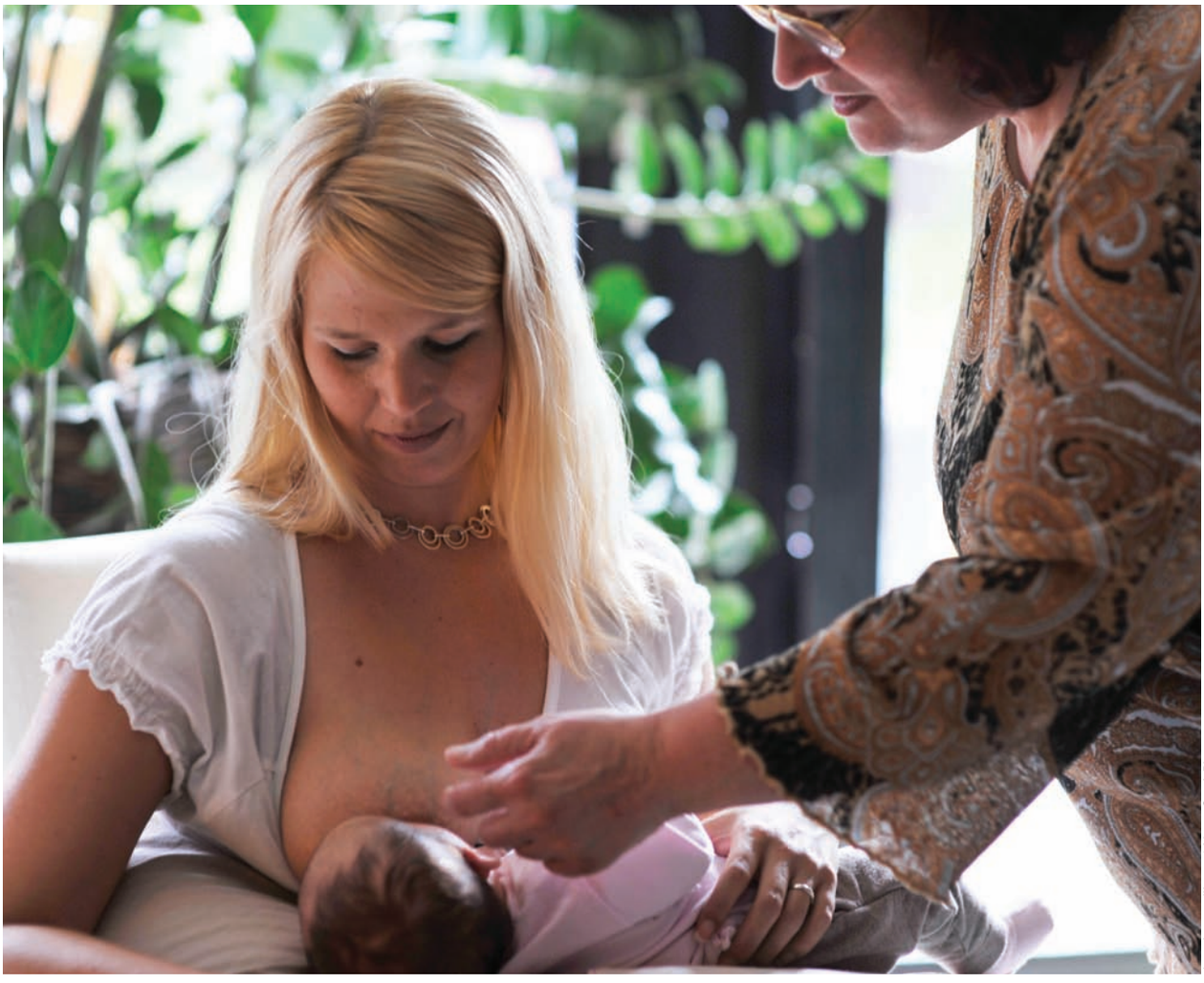
It is widely accepted that human milk, with rare exceptions, is the optimal method of feeding all infants. The World Health Organization (2009) recommends exclusive breastfeeding for infants up to 6 months of age and continued to 2 years and beyond with the addition of complementary foods. The Canadian Pediatric Society's position is that breastfeeding is the ideal and unequalled source of human nutrition and recommends exclusive breastfeeding for the first 6 months of infant life with continuation up to 2 years or more with appropriate complementary feeding (Critch, 2013). American sources, including the American Academy of Pediatrics (2012) and the Association of Women's Health, Obstetric and Neonatal Nurses (2015) call for supporting women to exclusively breastfeed for the first 6 months of infant life with continued breastfeeding into the first year, or longer. Despite these recommendations, many women who choose to breastfeed will discontinue well before the recommended 6 months (Sheehan, Krueger, Watt, Sword, & Bridle, 2001). Most often, the decision to stop breastfeeding is due to perceived difficulties with feeding rather than maternal choice (Dennis, 2002). Although there are various and multifaceted reasons for breastfeeding cessation, breastfeeding-related pain is a common occurrence for breastfeeding women and is an important contributor to breastfeeding cessation (Dennis, Jackson, & Watson, 2014).

Breastfeeding is a complex, learned behavior that is imbedded in a gendered, social and cultural context; often described as one of the more difficult processes of becoming a new mother (Johansson, Aarts, & Darj, 2010). The expectation that breastfeeding is easy and natural is often at odds with difficult experiences such as pain. Women experiencing pain while breastfeeding often use words like "dreadful", "indescribable", and "being in hell" (Kronborg, Harder, & Hall, 2015), yet giving up breastfeeding often leads women to feel a mixture of failure and guilt (Burns, Schmied, Sheehan, & Fenwick, 2010).



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Numerous studies suggest the primary barrier to supporting women through their breastfeeding challenges was inadequate knowledge and understanding of women's challenges associated with breastfeeding (Laanterä, Pölkki, & Pietilä, 2011). Despite the prevalence of breastfeeding-related pain and the negative impact it often has on breastfeeding outcomes, there is minimal evidence on this topic. A more complete understanding of this phenomenon is required to increase public awareness, to promote social support and to inform practices of healthcare professionals.

Study Design and Methods

Sample

This qualitative study used a feminist intersectional lens and methods consistent with Thorne's interpretive descriptive methodology (Thorne, 2016). Purposive sampling with a snowball approach (Thorne) was used to promote maximum variation on relevant phenomenon. A small estimated sample size of 20 was chosen as per interpretive descriptive lines of inquiry, with the understanding that there will always be more to study about a given phenomenon (Thorne). This study was conducted in 2016 in London, Ontario, Canada. Participants were recruited primarily through the regional public health unit's free Infant Growth/Development and Breastfeeding Drop-In clinics.

Breastfeeding-related pain is commonly experienced by women during postpartum and often contributes to breastfeeding cessation.

Due to slower than expected recruitment and a 4-month recruitment window (the funding agency stipulated a 12-month study from beginning to completion), the sample included 14 participants. To overcome low recruitment numbers, snowball sampling was implemented until saturation of categories and themes occurred.

Following approval from the Western University Office of Human Research Ethics Board, participants were recruited between May and October, 2016 from the public health unit. Inclusion criteria were postpartum women: 1) within 12 months of giving birth; 2) ≥19 years of age; 3) could speak and read English; and 4) were experiencing or had experienced breastfeeding-related pain within the past 2 months.

Data Collection

Informed consent was obtained followed by completion of a brief questionnaire containing demographic questions and the Short-form McGill Pain Questionnaire-2 (SF-MPQ-2)

(Melzack, 1987). Semistructured interviews were conducted, ranging from 30 to 90 minutes. A semistructured interview guide was used for all interviews, which included questions broadly related to the experiences of breastfeeding pain. Interviews were audio recorded and transcribed verbatim. Throughout the interview, data trustworthiness steps (Denzin & Lincoln, 2011) were used. Saturation was determined through iterative examination of all reoccurring themes and coding across participant interviews.

Data Analysis

Qualitative analyses were conducted independently and simultaneously by three investigators using interpretive descriptive methods. Each investigator initially reviewed the transcribed recordings. Transcripts were analyzed line-by-line for coding and item-by-item within NVivo 10 software (QSR NVivo 10, 2012, Doncaster, Victoria, Australia). Coded items were allocated to thematic nodes by each investigator. Further examination of nodes was independently conducted by each investigator to determine if nodes merited either further delineation (i.e., subnodes) or amalgamation (i.e., grouping into mother nodes). Consensus among investigators was achieved once the analysis was completed. Analysis and results of the quantitative data (SF-MPQ-2) are reported in a separate manuscript (Jackson, O'Keefe-McCarthy, & Mantler, 2018).

Results

Fourteen women participated in the study. Maternal and infant characteristics and demographics are outlined in Table 1 (Supplemental Digital Content, http://links.lww.com/MCN/A48). Findings suggested women's perceptions of breastfeeding were initially formed by their context and were further contextualized by the experience of breastfeeding-related pain, thus having an impact on her actions and outcomes. There were three key themes associated with breastfeeding and breastfeeding-related pain, including: 1) interplay between pain and women's context; 2) action enablers and/or barriers; and 3) outcomes.

Interplay Between Pain and Context

Given that the timing of when a woman decides to breastfeed is an important variable in predicting breastfeeding outcomes in the face of breastfeeding challenges (Dennis, 2002), it was important to have women contextualize their decision to breastfeed. For participants' decision to breastfeed, context such as: 1) normative/cultural beliefs of breastfeeding; 2) belief in the health and maternal–infant attachment benefits of breastfeeding; and 3) women's social context were identified as important contributors.

When women experienced breastfeeding-related pain, they often expressed feelings of guilt and self-judgment. One woman described the emotional ordeal that ensued resulting from her breastfeeding-related pain: *I felt terrible. I sat there and cried and I felt like a terrible mother for getting mad at [the infant], 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.* Another woman illustrated how her context, and her expectation of suffering alongside breastfeeding, shaped her experience of pain: *I don't know. I guess, just as a woman you're kind of brought up, like, this is what you're supposed to do, this is what you're supposed to be able to handle. So when you do experience pain, it's kind of like well, I'm supposed to be able to handle this pain 'cause it's just what — how I've been, like, I should be expecting this type of a thing.* One participant noted the experience of pain had an impact (albeit temporarily) on her feelings toward her infant son: *I didn't really want to feed him. And then as bad as this sounds, I would swear at him when he latched on, because it hurt that bad.*

Action Enablers and Barriers

The individual experience of breastfeeding-related pain in combination with each woman's context, culminated with women taking one of three pathways to deal with breastfeeding-related pain. First, women used *enablers to support breastfeeding*, which included a range of strategies such as formal and informal supports. Formal supports included caregivers such as midwives, nurses, chiropractors, and lactation consultants: One woman stated, *[The lactation consultant] gave me a nipple shield and gave me a whole gamut of strategies, like, she wrote out, which was great. So, I think I had a really good balance of supports.* Women discussed importance of informal supports, who were also key to achieving their breastfeeding goals, including friends, significant others, and family members. One woman described how being able to talk about her breastfeeding-related pain with her friends was critical to her ability to persevere through it: *[talking with friends] was one of the main reasons I honestly kept going too.* Women often discussed how their partners were important enablers, such as through their provision of verbal support or as a means of distraction. One woman stated, *just thinking of other things, like, either talking to my husband or watching TV, just trying to think of other things,* whereas another perceived her partner as coaching her through the pain: … *my husband was actually pretty good about talking me through it and just telling me it won't last forever.* For most women in this study, they found that support provided by their local public health nurses or lactation consultants was instrumental in helping them to find ways to alleviate, or work through their pain: *I was seeing them weekly…they were helping me with new positions… teaching me various ways to try and relax things…they were super supportive.* Although most women found the healthcare they received was generally supportive, they often spoke of receiving "mixed messages" on how to handle or manage their breastfeeding-related pain. One woman spoke of her experience seeking help from several, different healthcare providers: …*sometimes they're great. But it's always hard to evaluate if it's good advice or not really. Like, especially if it's contrary to what the midwife has told you.*

In the second pathway, women *identified and reduced barriers* associated with breastfeeding. Several women identified that reducing frequency of feedings could help to alleviate their pain. One woman distinguished the difference between feeding the infant for comfort versus feeding for nourishment, stating, *Once I realized he was comfort nursing versus actual nursing, I stopped him from the comfort nursing … he was feeding for 45 minutes on one side, and it would get pretty sore.* Several women realized the importance of proper positioning and latch and worked toward improving these techniques to relieve pain: *I tried to perfect my latch every time.* Several

women reflected that a barrier was a personal lack of knowledge or understanding that breastfeeding-related pain might be a part of their breastfeeding experience. Most women found having breastfeeding-related pain an unpleasant surprise and wished that they had known to anticipate and prepare for it. One woman, who took prenatal classes still felt unprepared for breastfeeding-related pain: *I still felt unprepared. I think [women] are going in kind of blind…when I was first describing that initial pain to [other breastfeeding friends] it's like, yeah, I had that too, so it's like very common across the board. It's something you don't really hear about. You don't really hear people say…like, the first few weeks, they're going to be rough. Like, you're going to be sore.* Another woman had a similar perspective: *I just want[ed] to know how common it is for this pain to happen…I feel so bad for people who go through this and have no knowledge or no help.*

In the third pathway, women used a *combination of enabling strategies and barrier reduction*. There were numerous examples that demonstrated these various strategies, in an almost "trial-and-error" approach in an effort to alleviate pain to keep breastfeeding. One woman stated, *…suck-in-my-breath, hold my breath...I tried some different positions...I did give her two formula feeds...just to give my nipples a break... I used some of that lanolin cream…I used some Tylenol.* Another woman described, *mentally preparing…also trying to reposition the baby and going to the clinics and talking to them about what hurts... reposition the baby to help try and ease the discomfort …I would try the football hold if I need to and I felt that was making a difference.*

Outcomes

There were two outcomes to breastfeeding-related pain: cessation or continuation of breastfeeding. For one woman who stopped breastfeeding due to pain, feelings of inadequacy and guilt were expressed because of her decision. Another woman described, *Feeling a little bit inadequate that I wasn't providing her [the infant] what she needed,* whereas another described the guilt associated with her thoughts around breastfeeding cessation: *I was having thoughts of …well, maybe this isn't for me… maybe I should switch to formula. But I definitely had been taught…that breast milk is best for your baby. So, I was in a position where…I felt bad for even considering that I was going to be switching to formula…so it was a feeling of guilt as well.* However, most women continued breastfeeding and persevered through the pain, which resulted in feelings of pride, relief, and success. As two mothers described their breastfeeding success, *I felt happy. I felt empowered. I felt…like I was doing so much good for her [infant]. I felt connected* and *So, I felt very frustrated. And then once it was all over I felt excited, happy, relieved that I was able to get through it and stick through it and continue to breastfeed.*

Discussion

Up until the last decade or so, within Canada, breastfeeding was not historically the norm. However, more recently, breastfeeding initiation rates have gradually increased. In Canada, breastfeeding initiation rates have increased from 85% in 2003 to 89% in 2012 (Gionet, 2013), similar to

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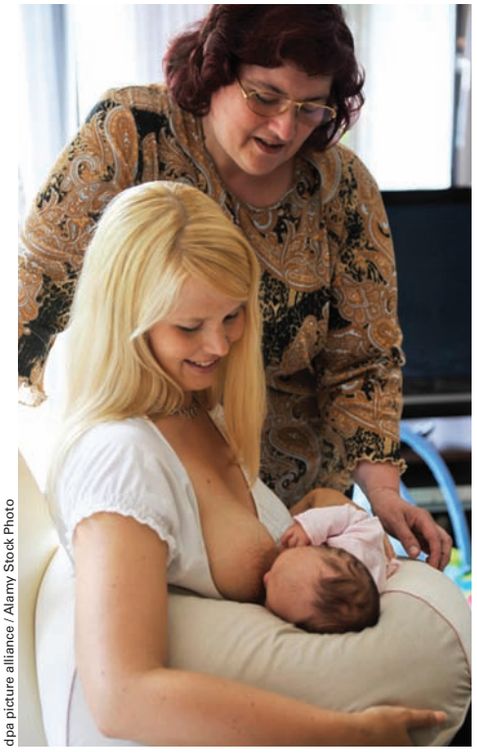
How women experience breastfeeding-related pain is not well understood.

that of the United States' rates rising from 74% in 2007 to 83% in 2016 (Centers for Disease Control and Prevention, 2016). Women in this study viewed breastfeeding as a personal and societal expectation. However, it is important to note they were primarily married, Caucasian, Canadian born, educated women. In Canada, women who breastfeed exclusively tend to be older with postsecondary educations, and those who do not tend to be younger, less educated, and single (Gionet). Among our participants, breastfeeding was an important and expected behavior that served as a motivator to initiate and persevere with breastfeeding in the face of pain. What is not understood is what happens to women who initiate breastfeeding, experience breastfeeding pain, but who lack social supports or who may lack resources to help with accessing other supports.

Women in this study often discussed the health and maternal–infant attachment benefits as an important factor in their decision to breastfeed, with the perception that "breast is best." Although this perception motivated women to initiate and continue breastfeeding, it also appeared to serve as a source of guilt when they experienced difficulty dealing with breastfeeding-related pain. Feelings of guilt are commonly experienced by women who are unable to breastfeed as they planned, regardless of the reasons for cessation (Chezem, Montgomery, & Fortman, 1997). Scholars have described how feelings of guilt and shame often affect mothers and have challenged the ways



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Suggested Clinical Implications

- Pregnant women require accurate information (at several points along the childbearing continuum) about the reality of breastfeeding.
- Prenatal breastfeeding education should be accurate and evidence-based, with information about the etiology and prevalence of breastfeeding pain. Education needs to be provided in such a way that does not deter women from breastfeeding but empowers them to be prepared and have management strategies and resources ready if needed.
- Nurses and other healthcare providers should be familiar with accessible and affordable breastfeeding support resources they can suggest to women in their communities.
- When providing antenatal and postpartum care to women, it is important to be sensitive to women's individual needs and be nonjudgmental—particularly for women experiencing breastfeeding challenges or who have decided to stop breastfeeding.
- When appropriate and accessible, assist postpartum women lacking partner (or other family or friend) supports to other peers or support groups in the community.

in which breastfeeding advocacy is currently enacted (Taylor & Wallace, 2012). With the understanding of the utility that guilt can have in encouraging "moral" behavior (Manion, 1964), health promotion strategies, including breastfeeding initiatives, often use guilt as a "tool" to encourage positive health-related behavior (Taylor & Wallace). For women who initiate breastfeeding but who are suffering with pain, these approaches may link to harmful outcomes. Several studies have highlighted the association with breastfeeding cessation and deleterious mental health outcomes including depression and anxiety (Pippins, Brawarsky, Jackson, Fuentes-Afflick, & Haas, 2006; Ystrom, 2012). Given that the relationship between pain-related breastfeeding cessation and maternal health outcomes has not been established, this is an important gap in the literature that warrants investigation.

Most women in this study described how their sources of social support were very important to them while dealing with breastfeeding-related pain. Many described how the public health nurses were instrumental in helping them problem solve through their breastfeeding challenges. Support contributes to breastfeeding outcomes. A recent Cochrane review confirmed that all forms of extra support (i.e., professional, or lay/peer) resulted in decreases in breastfeeding cessation, especially when support was face-to-face (McFadden et al., 2017). Family, peer, and professional support are critical to assisting mothers in achieving their breastfeeding goals. A metasynthesis of women's perceptions of breastfeeding support suggested a professional, balanced approach to support (i.e., positive but realistic, not over idealistic, encouraging, and proactive) was most effective in helping women achieve their breastfeeding goals (Schmied, Beake, Sheehan, McCourt, & Dykes, 2011). Our findings are consistent with evidence suggesting that partners' and fathers' positive attitudes toward breastfeeding are important contributors to breastfeeding success. A randomized controlled trial found that teaching fathers how to help manage lactation difficulties were associated with higher rates of continued breastfeeding at 6 months (Pisacane, Continisio, Aldinucci, D'Amora, & Continisio, 2005).

Most women used a combination of enabling strategies and barrier reduction approaches to deal with their pain. Our findings align with other studies suggesting women use numerous interventions to cope with their pain, such as: applying creams or lotions to the nipples (lanolin, all-purpose nipple ointments, and glycerin gels), using breast shields, and application of expressed breast milk (Dennis et al., 2014).

Participants experienced feelings of pride, happiness, success, and empowerment when they were able to get through their painful breastfeeding experience and continued to breastfeed. This sense of self-mastery, in terms of the attained experiential knowledge, skill, and ability to successfully breastfeed their infant has far-reaching potential. For some women who feel uncertain in their role of mother, the attainment of mastery with breastfeeding may potentially augment self-efficacy of other requisite mothering skills. It is well understood that maternal breastfeeding self-efficacy is a significant predictor of breastfeeding duration and exclusivity (Blyth et al., 2002). Women with higher levels of breastfeeding self-efficacy are more able to persevere through breastfeeding challenges, such as pain (Blyth et al.). The integration of strategies to promote breastfeeding self-efficacy may improve breastfeeding success, but may also contribute to maternal satisfaction and well-being. Further

research is required to gain a better understanding of how nurses and support persons can enhance breastfeeding self-efficacy in the face of breastfeeding-related pain.

Limitations

Despite our efforts to recruit a diverse sample, participants were demographically homogeneous, including only well-educated women between 25 and 36 years of age. A gap remains on how breastfeeding pain affects women who are marginalized, of lower income, immigrant or who are Indigenous, and of other age-groups. There was a wide range of ages among infants being breastfed by women in this sample (2–49 weeks). Further research is warranted to better understand the uniqueness of breastfeeding pain experiences considering newborns and infants of various ages.

Clinical Implications

Women emphasized the critical importance of partner, peer, and professional support in helping them navigate their experience of breastfeeding-related pain. Nurses need to ensure that women have adequate support and offer nonjudgmental evidence-based information. Women who may not have the benefit of family or friends who will support their breastfeeding should be referred to accessible resources. If a new mother decides not to breastfeed as a result of their difficulties, nurses can support them through the resolution of potentially associated negative feelings.

Women need the best-available evidence to support their breastfeeding decision. Many of the interventions currently being recommended by nurses have questionable efficacy, with limited evidence available to support recommending any specific type of treatment for breastfeeding-related pain (Dennis et al., 2014). Women need accurate information on what interventions are available to them, and which are most efficacious. Suggesting interventions that are not effective for breastfeeding-related pain may promote increased frustration or guilt when they follow instructions but their pain is not well managed. Our findings underscore the need to prevent breastfeeding-related pain. Breastfeeding-related pain is often a result of improper latch or infant positioning at the breast. Nurses caring for women after birth are well positioned to provide assistance immediately after birth, with the goal of preventing the onset of breastfeeding-related pain. Although the Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN) does not specifically address the issue of breastfeeding-related pain, their position statement on breastfeeding calls for nurses and other healthcare providers to have the knowledge and competence required to provide evidence-based breastfeeding information and support throughout the preconception, antenatal, and postpartum periods (AWHONN, 2015). They refer to the United States Breastfeeding Committee Core Competencies for breastfeeding care (2010), including the competency of preparing families for realistic expectations.

Mothers found breastfeeding-related pain to be an extremely unpleasant and unexpected event in their postpartum experience. They often called for changes around how nurses educate women about breastfeeding, and for a more transparent explanation about what they could have expected in terms of pain and how to best prepare for breastfeeding challenges. Despite this, women who felt supported and persevered through their breastfeeding-related pain experienced significant feelings of pride, success, and happiness with respect to their breastfeeding and their perceptions of motherhood. Anticipatory guidance, an important strategy used to decrease stress and promote coping in the perinatal period may be a worthwhile intervention to explore among women experiencing breastfeeding-related pain. Research suggests that for most women, breastfeeding-related pain reaches mild levels after approximately 7 to 10 days postpartum (Jackson & Dennis, 2018). Participants stated that they wished they had known about breastfeeding-related pain, so that they might have anticipated it, and prepared themselves for it; much like they did in preparation for labor. There may be benefit to providing pregnant women with information about prevalence, etiology, and management of breastfeeding-related pain, and reinforcing this information again in the immediate postpartum period. Education on breastfeeding-related pain could be provided prenatally and immediately postpartum. More research is needed to evaluate effectiveness of anticipatory guidance for breastfeeding-related pain and its effectiveness on women's coping and breastfeeding outcomes.

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LPD will award 1.5 contact hour for this continuing nursing education activity.

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This activity is also provider approved by the California Board of Registered Nursing, Provider Number CEP 11749 for 1.5 contact hour. LPD is also an approved provider of continuing nursing education by the District of Columbia, Georgia, and Florida CE Broker #50-1223.

Payment:

- The registration fee for this test is $17.95.