Abstract

Objectives To explore the views and experiences of women with Pregnancy related Pelvic Girdle Pain (PPGP), and to inform the design and development of a subsequent feasibility study.

Design Using a philosophical stance of pragmatism, one-to-one audio recorded semi-structured interviews were used. All interviews were conducted once by a male interviewer, and analysed using an interpretive thematic data analytic approach through five steps: transcription, precoding, coding, categorisation and theme generation, with reflexivity adopted throughout the data synthesis process.

Setting A Women’s Health Physiotherapy Department in the North East of England between April 2014 to June 2014

Participants Eight pregnant women suffering with Pregnancy related Pelvic Girdle Pain

Main Outcome measures Women’s experiences of Pregnancy related Pelvic Girdle Pain

Results Three themes emerged: Reality of Pregnancy related Pelvic Girdle Pain; Key Mechanisms of Support and; Impact of Knowledge. Participants reported biopsychosocial symptoms, which included pain, reduced activities of daily living, psychological distress and social isolation. Participants valued the support of a healthcare professional through face to face contact and the interventions that they provided, as well as information on the condition.

Conclusions Whilst there were some limitations to this study, the biopsychosocial symptoms discussed here justify the investigation of acupuncture for Pregnancy related Pelvic Girdle Pain. The design and development of a subsequent feasibility study, specifically in areas of recruitment, acceptability of the intervention and appropriate selection of outcome measures were informed by this study.
Title:
A qualitative exploration of the views and experiences of women with Pregnancy related Pelvic Girdle Pain

Contribution of the paper

- Identification of a range of symptoms: PPGP symptoms included pain, reduced ADL’s, psychological distress and social isolation
- Exploration of experiences and need for support: PPGP sufferers valued support mechanisms from a co-inhabiting partner, a healthcare professional, and information on the condition.
- Informed the design and development of a feasibility study investigating acupuncture for Pregnancy related Pelvic Girdle Pain

Keywords
Pregnancy; Pelvic Girdle Pain; PPGP; Qualitative; Interviews; Women’s views

Tweetable abstract
Biopsychosocial symptoms and the value of support mechanisms influenced the design and development of a feasibility study for acupuncture in PPGP
Introduction

Pregnancy related Pelvic Girdle Pain (PPGP) affects approximately 20% of pregnant women [1], though incidence rates differ markedly when explored in different countries [2]. It is defined as ‘...experienced between the posterior iliac crest and the gluteal fold, particularly in the vicinity of the Sacro-Iliac Joint. The pain may radiate into the posterior thigh and can also occur in conjunction with/or separately in the symphysis’ (p.797) [3]. Whilst some researchers consider Low Back Pain in pregnancy (LBPP) and PPGP as being indistinguishable [4], others focus upon specific subsets of PPGP (such as Symphysis Pubis Dysfunction) [5]; however, most authors now consider LBPP and PPGP as separate entities [6, 7].

Pain in PPGP is frequently reported between 50mm and 60mm on a Visual Analogue Scale [6], and it can negatively impact upon Activities of Daily Living (ADL) [8-10]. Physical symptoms can be assessed through outcome measures such as the Pelvic Girdle Questionnaire (PGQ) [8], which is considered valid and reliable in Scandinavian populations [11]. Furthermore, qualitative studies have explored the experiences of PPGP sufferers and have identified psychosocial effects [12-15]. These studies have adopted one to one, semi-structured interviews conducted by females [12-15], performed thematic analysis, and have included between five [13] and twenty-seven women [14]. However, these qualitative studies emanate from Scandinavia, and therefore speculatively, if the difference in observed incidence rates in different countries [2] are due to sociocultural factors, may not accurately reflect the views and experiences of UK-based PPGP based sufferers. Furthermore, existing UK-based qualitative studies that have explored PPGP views and experiences have focused upon Symphysis Pubis Dysfunction [4,5], and not PPGP more generally.

Given its impact upon pain and psychosocial health [12-16] in one fifth of pregnancies [1], safe, effective and acceptable interventions for PPGP are required. To date, acupuncture has shown promising results for PPGP [7] and appears to be safe [17], but has yet to be investigated thoroughly. In order to assess its efficacy through a robust Randomised Control Trial (RCT), a feasibility study investigating acceptability and practicality of acupuncture is warranted [18]. Components of a
feasibility study, such as recruitment, acceptability of the intervention and appropriate selection of
outcome measures, are more likely to be sufficient if researchers engage with the target population
[18]. These components can be explored most appropriately through a qualitative research paradigm,
which in its broadest scope, sets out to gain a deeper understanding of a given situation or
phenomenon [19].

This qualitative study explored the PPGP sufferer’s views and experiences of biopsychosocial
symptoms and what they considered to be important factors in its management. In order to compare
with existing qualitative studies, one to one, semi structured interviews were conducted. The results
were used to inform the design and development of a subsequent mixed methods feasibility study
(MMFS), and gauge whether PPGP sufferers would be willing to enroll and commit to it.

Aim
To explore the views and experiences of women with PPGP, and to inform the design and
development of a subsequent MMFS.

Methods
Underpinning philosophy
Pragmatism is defined as “a philosophy in which the meaning of actions and beliefs are found in their
consequences” (p.26) [20]. Pragmatists believe that because no experience can be exactly like
another, two people cannot have an identical worldview; this presents value to research conducted by
different people on the same topic, and the researcher should continuously reflect upon the outcomes
of their research to evolve their understanding [20-22]. Although Pragmatism is not universally
accepted [20], it is adopted frequently in mixed methods studies [20, 23-25]. Given that this
qualitative study informed a MMFS, pragmatism was adopted to remain consistent with existing
mixed-methods research [20, 23-25].

Study design and sample
Semi-structured, audiotaped, one to one interviews were conducted by CC in a Women’s Health physiotherapy department (WHPD) located in the North East of England. A purposeful sample of up to eight PPGP sufferers were to be recruited from the WHPD. The target number of participants was considered to reflect previous PPGP studies [13, 15], whilst remaining manageable for one interviewer to conduct within a three-month period.

Recruitment, data collection and analysis

Women attended their usual physiotherapy appointment, and were diagnosed with PPGP by their Women’s Health physiotherapist (WHP) if they complained of pain in the pelvic girdle region since becoming pregnant, and if it was not related to an internal organ / potentially sinister pathology. Women were eligible for this study if they:

- Were diagnosed with PPGP
- Had a singleton pregnancy beyond the first trimester
- Recognised English as their first language

There were no exclusion criteria.

Each eligible woman was given a participant information sheet by their WHP, detailing the study purpose, benefits, and risks of taking part. An interested potential participant would contact CC to arrange their interview at the WHPD; on attendance they were given the opportunity to ask questions, and then provided signed consent. The participant and CC had had no previous contact, but the participant knew from reading the Participant Information Sheet CC’s gender, professional background, and purpose of doing the study. In keeping with previous PPGP research, participants provided demographic data prior to beginning the interview via a pre-printed form designed, for this study, by CC (see Table 1). The interviewer maintained a conversationalist manner throughout each interview, and field notes were taken to aid with reflexivity during analysis. Reflexivity, adopted by CC and reported throughout this paper, is unique to qualitative research, and ensures that the researcher makes it clear how they may have influenced data collection and analysis [26], and
strengthens the trustworthiness of the conclusions drawn. At the end of the interview, participants were asked to read the PGQ for their opinion on its representativeness of their PPGP.

The interview schedule was prepared by both authors, and included main, open ended questions with neutral wording, and probing questions to expand upon responses (see Table 2) [27]. Questions were formulated from the existing literature and framed objectively by the researcher who, due to gender, had no personal experience of the condition. Review of the interview schedule was conducted with four WHP’s to ensure that principal topic areas for PPGP were addressed. An interpretive, thematic data analytic approach [26] was adopted by CC for all interviews (see Table 3). Transcripts were typed and anonymised by CC.

Results

Eight participants completed one interview each within a four-week period (see Table 1 for demographics). Data saturation occurred after the sixth participant. Interviews lasted between 50 to 70 minutes. Although no women declined to take part on contact with CC, data on whether potential participants who were given the information sheet, but did not follow up on the opportunity, was not recorded.

After data reduction from coding, ten categories emerged leading to three overarching themes (see Tables 4 and 5). Constant comparison was adopted by CC throughout data analysis, which ensured that the categories and themes accurately reflected the raw data from all transcripts. NA independently cross-checked transcripts with the themes to ensure any unaccounted bias from CC did not influence the synthesised data. No software was used to manage the data.

The reality of PPGP

Pain impacted on all aspects of their life, including restrictions to ADL’s and their psychosocial health, which is consistent with previous studies [2-6,12-16, 28-30]. All participants described PPGP onset as insidious and within the second trimester. They sought medical advice early because they
were concerned about the pain, or only sought medical attention when the pain reached a higher intensity or frequency. They described symptoms as:

“…an unbearable pain”

or

“…constantly feeling your pelvis is going to fall off…” (P8).

One participant stated that, at times, she had felt that:

“…my baby is just going to come out” (P4).

A biopsychosocial picture developed, because their mood had changed since developing PPGP. Although three participants acknowledged that this could be due to general pregnancy, there was an emphasis that the pain was to blame:

“It hurts so it does make you emotional it doesn’t help with the hormones that you have when you're pregnant as well so you think everything’s ten times worse” (P3),

and:

“It’s making me sad [laugh] cos I can’t … get on and do things as normal I just want to get on with life” (P2).

Their ability to function in usual social surroundings was also affected:

“I’m normally like a socially active person. It has made me the most miserable anti-social person…cos I’m in too much pain” (P3).

Two participants reported social isolation:

“...don’t really go out much I just speak to my friends over the internet” (P5),

and:

“I’m just avoiding making plans altogether…I’m not good company once it sets off [laugh]” (P4).

This theme indicates that PPGP invades all areas of the sufferer’s lives, and thus contributes to physical, psychological and social distress. Furthermore, the PGQ was confirmed by all women to accurately reflect their symptoms:
“I find all of that hard so yeah it’s most things what people with this pain would suffer with and have to deal with” (P1).

Key Mechanisms of Support

Support from family and friends was considered integral to dealing with PPGP:

“It’s definitely reassuring...to know that your mum went through it...people’s forums...friends who have had babies...nothing they can do but just to listen to you moan about it, this helps” (P7).

and:

“I think I would be lost...there really is an emotional side to it you can sort of deal with it a bit more when you talk with other people” (P7).

Participants could also imagine what it would be like to not have a supportive co-inhabiting partner:

“Well I know I would struggle cos he is away now...so I’ve got friends coming to stay with me so I’m not on my own...” (P5).

One participant, who had ended a relationship, expressed that:

“I wasn’t in the best relationship anyway so I think that made it (PPGP)...20 times worse...” (P8), which demonstrates the extent to which social support can influence symptom severity, and provides further evidence that PPGP is biopsychosocial.

All women considered healthcare professionals as an important support mechanism, primarily through knowledge provision and interventions that may help alleviate their pain. To establish how important an intervention was as a support mechanism, each participant was asked what a treatment would need to provide:

“...anything that even just took it away a little bit is helpful” (P6).

and:

“To come in once or twice a week it would probably have to stop the pain altogether...” (P5).

However, painkillers were viewed with caution:
“You can’t take medication when you’re pregnant apart from paracetamol and that doesn’t work...If it was safe for the baby, fine, if it didn’t affect the baby” (P7).

Impact of Knowledge

Three women believed that non-sufferers did not understand PPGP:

“I think potentially it wouldn’t even be taken seriously for someone who had never experienced anything like it before” (P6).

and:

“I just feel like nobody understands what I’m going through” (P8).

If non-sufferers had a similar issue such as low back pain, those people were more empathetic towards the PPGP sufferer:

“There’s a girl that I work with who has sciatica...and she’ll kind of understand the limitations a bit more” (P4).

All participants considered the NHS website as a reputable source of knowledge:

“...everything the NHS tells you is right and it’s true about SPD and stuff like that...” (P2),

but it was not enough:

“...a lot of the information that was on the NHS website was quite generalised” (P3),

and:

“...too much for me because I don’t understand all the jargon words” (P1).

All participants acknowledged the shortcomings of blogging sites:

“...that’s where half the horror stories come from...I think people have clearly needed an outlet for their stories or for their experiences that have happened to them...” (P5).

Despite using the internet as a source of knowledge, there was recognition that websites alone were not sufficient:

“...you need to hear it from your doctor or your midwife...you just worry yourself and go into a panic” (P4).
In general, information surrounding PPGP pre-diagnosis was scarce:

“...something that isn’t out there it (is) something that they don’t tell you” (P6).

Symptoms could have been exacerbated by not knowing what the cause was, with one participant stating:

“...it was quite bad at the beginning not knowing what it was” (P1).

One of the women suggested that the lack of diagnosis contributed to her hospital stay:

“...if I had of know it was this (PPGP) then I would have left” (P8).

Perhaps the most striking comment of:

“I just thought I was losing the baby” (P6),

demonstrates the level of distress not knowing can create.

Participants expressed most fear when they felt PPGP had potentially severe implications:

“I just thought I was losing the baby” (P6).

and:

“I didn’t really know what it was...I didn’t know if it was something serious” (P3).

and:

“I was really, really, worried that if something happened to my son, what was I going to if he fell over” (P4).

Yet, once a healthcare professional provided information, there was a positive impact:

“I’m alright with it, cos I think, it’s like, I know what it is now” (P7).

and:

“...hearing that it was manageable was quite a relief” (P1)

and:

“...she gave me so much more information which was really helpful ...she told me that yes it’s related to your pregnancy, em, it’s called this, this is what it means... I felt I had more understanding about it, em, because up to that point I was pretty much completely in the dark” (P4).
This not only reiterates the influence of the psychological element of PPGP, but emphasises the importance of the healthcare professional as a key support mechanism.

Discussion

Main Findings

Consistent with previous research [2-6,12-16, 28-30], symptoms of pain, reduced ADL’s, and psychological distress were all described. The pain was a physical discomfort which prevented usual ADL’s, it became a source of serious concern and therefore distress, and in some cases greatly reduced social interactions. The severity of these biopsychosocial symptoms indicate that an intervention study, aimed at alleviating PPGP, would be considered acceptable. Caution around taking painkillers was noted in this study and in previous research [31], which could prevent recruitment to a medication study, and therefore justifies investigating non-pharmaceutical methods such as acupuncture, which may have some benefit for PPGP symptoms [7] and appears to be safe to administer [17]. However, despite one participant in this study believing any pain relief would be welcome, another participant suggested the acceptability of an intervention, such as acupuncture, could be influenced by the time commitment needed to undergo a course of treatment. This strengthens the need for feasibility testing prior to adopting a larger scale study.

Comments around the support of a healthcare professional, and the value placed upon PPGP knowledge, suggested that recruitment to a study would be favourable if it was based in a WHPD, and if the study included PPGP information. Subsequently, the acupuncture MMFS design included PPGP information provision, and was conducted in a WHPD.

Furthermore, outcome measure selection for the MMFS was influenced by comments made in this study. The time commitment comment prompted CC to include a post feasibility study questionnaire to record views on the practicalities of attending regular acupuncture clinics, as recruitment and retention to a study can influence the success of any post-feasibility RCT [18]. In addition, all participants acknowledged the PGQ reflected their symptoms, and it was therefore included in the
Moreover, the findings of this study emphasised issues outside of the feasibility-informing lens. All participants discussed the importance of their co-inhabiting partner when dealing with PPGP. One woman, who had ended a relationship with her partner, stated it had made dealing with PPGP difficult, and another woman discussed anxiety at the prospect of her partner being absent. This is consistent with previous research [14, 15, 29], and advocates involving the co-inhabiting partner in PPGP management.

Finally, participants expressed anxiety when PPGP first appeared, consistent with previous studies [5, 12-14, 28-30], and reported relief once they had information on their symptoms. These results suggest women frequently use the NHS website and online forums for information on PPGP. However, a knowledgeable health professional was seen as an important support mechanism, which is observed in previous studies [13, 28, 29]. Speculatively, if PPGP information was provided in early pregnancy, it could lead to a decrease in anxiety.

**Strengths & Limitations**

The researcher’s experience in interviewing patients as a Physiotherapist facilitated the flexible interaction with each participant, which allowed for a rich data discussion [22]. Furthermore, being male provided CC a level of detachment from the interviewee’s, which some authors believe enhances rigour [28, 32]. When researchers and participants share experiences, the risk is that participants may leave things unsaid which they believe to be obvious [32].

The adoption of pragmatism could have influenced data collection and synthesis, as this study was planned to help inform a MMFS. By investigating PPGP experiences through this lens, it may have exaggerated or underplayed information that was provided by participants. Being aware that the feasibility-informing purpose could influence data, CC attempted to mitigate any biases through
constant comparison, and NA agreed that the data reduction and synthesis accurately reflected the
interviews.

Conversely, there are several areas which should be addressed in future research. Credibility,
authenticity and transferability could have been enhanced through a larger sample and triangulation,
and through additional focus groups and follow up interviews. Member checking would have
provided additional credibility to this work [26], as participants could have provided comments on
whether they thought the reduced data accurately reflected their experiences. To enhance rigour, a
male interviewer could dovetail with a female interviewer who has experienced PPGP, as a stranger to
a culture may miss clues that are clear to an ‘insider’ [33]. Although enrolled participants were
talkative, they may not have felt comfortable disclosing some information. Being a male who has
never experienced PPGP, the wording, use of language and delivery of questions during the interview
may have been different to a woman who could be empathetic [32,33]. Moreover, if the interviewer is
viewed as being part of the interviewee’s community, it can enhance recruitment [32].

Finally, the interview location, in this case the WHPD, can influence the data collection process [34],
and CC’s decision to dictate this, shifts power towards the interviewer [35]. The participants in this
study attended a physiotherapy department and were recruited and interviewed by a physiotherapist,
so the emphasis upon positive physiotherapy interactions could have been influenced by this
environment. To counter this effect, participants should have chosen the interview location [35],
which could have led to a more in-depth discussion with each participant.

**Conclusion**

This study suggests PPGP is a biopsychosocial issue, with descriptions of pain, reduced ADL’s,
psychological distress and social isolation all apparent. Support via the co-inhabiting partner and
knowledgeable healthcare professional, as well as information upon PPGP, were considered vital to
dealing with the condition. Given the regard in which support was held, and the impact of
biopsychosocial symptoms, these findings justify future research into interventions for PPGP.
Acupuncture has a promising evidence base, but requires further research in the form of a feasibility study to establish its acceptability and practicality of delivery. This qualitative study informed the subsequent MMFS design through study location, suitable outcome measures to adopt, and the provision of PPGP information.

Rigour is observed in this study through constant comparison and CC being male, which allowed for a degree of detachment from the participants, yet there are limitations that prevent stronger generalisations. Therefore, future UK based qualitative studies should include a larger sample, interviewed by both a male and PPGP sufferer, allow participants to choose the interview location, and adopt member checking and triangulation within the study design.

**Conflict of Interest**

CC and NA report no conflict of interest.

**Ethical Approval**

Approval was granted by the Faculty of Health and Life Sciences Research Ethics Review Panel, 24th October, 2013, ref. number: RE-HLS-12-130701-51d1815248c3f. It was then passed for ethical approval via Newcastle and North Tyneside 1 NRES Committee 2.4.2014, reference number 14/NE/0060, 7th April 2014. This study has an IRAS ID 135428.

**Funding**

This research did not receive any grant from funding agencies in the public, commercial, or not-for-profit sectors.
### Table 1
Participant demographics

<table>
<thead>
<tr>
<th>Participant</th>
<th>Age</th>
<th>Gestation at interview (weeks)</th>
<th>Number of weeks with PPGP</th>
<th>Highest education qualification</th>
<th>Exercise hours per week</th>
<th>With a co-inhabiting partners</th>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>29</td>
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<td>5</td>
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<td>2</td>
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<td>6</td>
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<td>3</td>
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<td>21</td>
<td>10</td>
<td>Degree</td>
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<td>4</td>
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<td>22</td>
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<td>NVQ</td>
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<td>29</td>
<td>11</td>
<td>A-level</td>
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<td>6</td>
<td>20</td>
<td>30</td>
<td>14</td>
<td>NVQ</td>
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<td>8</td>
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<td>21</td>
<td>8</td>
<td>A-level</td>
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</tr>
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</table>

Demographic data collected to remain comparable to existing PPGP studies [8,13,14,]
<table>
<thead>
<tr>
<th><strong>Main Questions</strong></th>
<th><strong>Probing Questions</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>What is it like to be pregnant?</td>
<td>Is it what you expected?</td>
</tr>
<tr>
<td>What does the diagnosis of PPGP mean to you?</td>
<td>Is pain the main problem?</td>
</tr>
</tbody>
</table>
| How would you describe PPGP? | To yourself, before you developed it  
To a female friend considering becoming pregnant  
To a person who has been pregnant but not experienced pelvic girdle pain |
| What do you think other people who do not have PPGP think about it? | For example, health professionals?  
Close friends / family?  
Work colleagues / employers? |
| How does your PPGP affect your day-to-day life? | Does it restrict you?  
Is pain the main problem?  
Is it something you would seek medical treatment for? |
| Do you have any concerns about PPGP? |  |
| How do you manage your PPGP? | Do you feel it has helped?  
How do you feel about taking medication?  
How do you feel about performing exercises? |
| What options are you aware of that may help with your PPGP? | Access to health professionals within / outside of the NHS?  
Are you aware of an approach that has not been suggested by a health professional? |
| Is there anything you have found that does not help with your PPGP | Is there anything that has made it worse?  
Is there any advice you would give others? |
| What would be an “effective” treatment for you? | Reduction / removal of some symptoms?  
Reduction / removal of all symptoms? |
| What would be an “ineffective” treatment to you? | Too time consuming?  
Demonstrated small affects?  
Gave only short lived benefits?  
Reduction in pain only? |
| Do you think this tool would accurately reflect the issues that you are dealing with? *(Shown a PPGP outcome measure)* | Is there anything on there that is irrelevant to you?  
Is there anything on the outcome measure that should be changed?  
Is it easy to follow / use? |
Table 3
Data Analysis stages

<table>
<thead>
<tr>
<th>Data Analysis stage</th>
<th>Data processing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Data collection</td>
<td>Interview, transcription, field notes</td>
</tr>
<tr>
<td>Pre-coding</td>
<td>Transferring data from the transcriptions to a pre-coding Word document. Adopted for each interview individually</td>
</tr>
<tr>
<td>Coding</td>
<td>Raw data labelled under a subheading that encompassed a commonality between the raw data extracted</td>
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<tr>
<td>Categorisation</td>
<td>Codes from all interviews analysed, and then grouped together. A category label was produced which reflected the codes’ meaning</td>
</tr>
<tr>
<td>Themes</td>
<td>Four themes synthesised from the categories. Themes are presented in the results section</td>
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</tbody>
</table>
### Table 4

**Codes that informed categories**

<table>
<thead>
<tr>
<th>Categories</th>
<th>Onset of PPGP</th>
<th>Impact on psychosocial</th>
<th>Expectations of PPGP</th>
<th>Healthcare experience</th>
<th>Support from family and friends</th>
<th>Treatment</th>
<th>Perceptions of others</th>
<th>Fear</th>
<th>Importance of Knowing</th>
<th>Looking up the problem</th>
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<tbody>
<tr>
<td><strong>Codes</strong></td>
<td>Duration</td>
<td>Onset</td>
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<td>Being pregnant</td>
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<td>Not fun</td>
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<td>Process of diagnosis</td>
<td>Sacrifice</td>
<td>Preventative measures</td>
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<td>Description of symptoms</td>
<td>Impact on ADL’s</td>
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<td>Psychophysical impacts other than pain</td>
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<td>Social impacts</td>
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<td>Feelings of guilt</td>
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### Table 5
Categories that informed themes

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<td>Looking up the problem</td>
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References


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[32]. Berger, R. Now I see it, now I don’t: reseracher’s position and reflexivity in qualitative research’ Qualitative Research 2015; 15(2): 219–234.


[34]. Sin, C. Interviewing in “place”: The socio-spatial construction of interview data. AREA 2003;
[35]. Manderson, L. Bennett, E. and Andajani, S. The Social Dynamics of the Interview; Age, Class, and Gender Qualitative Health Research 2007; DOI: 10.1177/1049732306294512.