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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

1 **Introduction**

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

10

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

23

24 Given its impact upon pain and psychosocial health [12-16] in one fifth of pregnancies [1], safe,
25 effective and acceptable interventions for PPGP are required. To date, acupuncture has shown
26 promising results for PPGP [7] and appears to be safe [17], but has yet to be investigated thoroughly.
27 In order to assess its efficacy through a robust Randomised Control Trial (RCT), a feasibility study
28 investigating acceptability and practicality of acupuncture is warranted [18]. Components of a

29 feasibility study, such as recruitment, acceptability of the intervention and appropriate selection of
30 outcome measures, are more likely to be sufficient if researchers engage with the target population
31 [18]. These components can be explored most appropriately through a qualitative research paradigm,
32 which in its broadest scope, sets out to gain a deeper understanding of a given situation or
33 phenomenon [19].

34

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

40

41 **Aim**

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

44

45 **Methods**

46 *Underpinning philosophy*

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

55

56 *Study design and sample*

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

62

63 *Recruitment, data collection and analysis*

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

67 Women were eligible for this study if they:

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

71 There were no exclusion criteria.

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

83 strengthens the trustworthiness of the conclusions drawn. At the end of the interview, participants
84 were asked to read the PGQ for their opinion on its representativeness of their PPGP.

85

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

93

94 **Results**

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

100

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

106

107 *The reality of PPGP*

108 Pain impacted on all aspects of their life, including restrictions to ADL's and their psychosocial
109 health, which is consistent with previous studies [2-6,12-16, 28-30]. All participants described PPGP
110 onset as insidious and within the second trimester. They sought medical advice early because they

111 were concerned about the pain, or only sought medical attention when the pain reached a higher
112 intensity or frequency. They described symptoms as:

113 *“...an unbearable pain”*

114 or

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

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

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

118 A biopsychosocial picture developed, because their mood had changed since developing PPGP.

119 Although three participants acknowledged that this could be due to general pregnancy, there was an
120 emphasis that the pain was to blame:

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

123 and:

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

126

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

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

130 Two participants reported social isolation:

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

132 and:

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

135 This theme indicates that PPGP invades all areas of the sufferer’s lives, and thus contributes to
136 physical, psychological and social distress. Furthermore, the PGQ was confirmed by all women to
137 accurately reflect their symptoms:

138 *“I find all of that hard so yeah it’s most things what people with this pain would suffer with*
139 *and have to deal with” (P1).*

140

141 Key Mechanisms of Support

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

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

146 and:

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

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

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

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

153 *“I wasn’t in the best relationship anyway so I think that made it (PPGP)...20 times worse...”*
154 *(P8),*

155 which demonstrates the extent to which social support can influence symptom severity, and provides
156 further evidence that PPGP is biopsychosocial.

157

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

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

163 and:

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

165 However, painkillers were viewed with caution:

166 “You can’t take medication when you’re pregnant apart from paracetamol and that doesn’t
167 work...If it was safe for the baby, fine, if it didn’t affect the baby” (P7).

168

169 Impact of Knowledge

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

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

173 and:

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

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

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

179

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

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

182 but it was not enough:

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

184 and:

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

186 All participants acknowledged the shortcomings of blogging sites:

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

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

191 “...you need to hear it from your doctor or your midwife...you just worry yourself and go into
192 a panic” (P4).

193

194 In general, information surrounding PPGP pre-diagnosis was scarce:

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

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

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

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

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

201 Perhaps the most striking comment of:

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

203 demonstrates the level of distress not knowing can create.

204

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

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

207 and:

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

209 and:

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

212

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

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

215 and:

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

217 and:

218 *“...she gave me so much more information which was really helpful ...she told me that yes
219 it’s related to your pregnancy, em, it’s called this, this is what it means... I felt I had more
220 understanding about it, em, because up to that point I was pretty much completely in the
221 dark” (P4).*

222 This not only reiterates the influence of the psychological element of PPGP, but emphasises the
223 importance of the healthcare professional as a key support mechanism.

224

225 **Discussion**

226 *Main Findings*

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

239

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

244

245 Furthermore, outcome measure selection for the MMFS was influenced by comments made in this
246 study. The time commitment comment prompted CC to include a post feasibility study questionnaire
247 to record views on the practicalities of attending regular acupuncture clinics, as recruitment and
248 retention to a study can influence the success of any post-feasibility RCT [18]. In addition, all
249 participants acknowledged the PGQ reflected their symptoms, and it was therefore included in the

250 subsequent, as yet unpublished, feasibility study.

251

252 Moreover, the findings of this study emphasised issues outside of the feasibility-informing lens. All
253 participants discussed the importance of their co-inhabiting partner when dealing with PPGP. One
254 woman, who had ended a relationship with her partner, stated it had made dealing with PPGP
255 difficult, and another woman discussed anxiety at the prospect of her partner being absent. This is
256 consistent with previous research [14, 15, 29], and advocates involving the co-inhabiting partner in
257 PPGP management.

258

259 Finally, participants expressed anxiety when PPGP first appeared, consistent with previous studies [5,
260 12-14, 28-30], and reported relief once they had information on their symptoms. These results suggest
261 women frequently use the NHS website and online forums for information on PPGP. However, a
262 knowledgeable health professional was seen as an important support mechanism, which is observed in
263 previous studies [13, 28, 29]. Speculatively, if PPGP information was provided in early pregnancy, it
264 could lead to a decrease in anxiety.

265

266 *Strengths & Limitations*

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

272

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

277 constant comparison, and NA agreed that the data reduction and synthesis accurately reflected the
278 interviews.

279

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

291

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

298

299 **Conclusion**

300 This study suggests PPGP is a biopsychosocial issue, with descriptions of pain, reduced ADL's,
301 psychological distress and social isolation all apparent. Support via the co-inhabiting partner and
302 knowledgeable healthcare professional, as well as information upon PPGP, were considered vital to
303 dealing with the condition. Given the regard in which support was held, and the impact of
304 biopsychosocial symptoms, these findings justify future research into interventions for PPGP.

305 Acupuncture has a promising evidence base, but requires further research in the form of a feasibility
306 study to establish its acceptability and practicality of delivery. This qualitative study informed the
307 subsequent MMFS design through study location, suitable outcome measures to adopt, and the
308 provision of PPGP information.

309

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

315

316 **Conflict of Interest**

317 CC and NA report no conflict of interest.

318

319 **Ethical Approval**

320 Approval was granted by the Faculty of Health and Life Sciences Research Ethics Review Panel, 24th
321 October, 2013, ref. number: RE-HLS-12-130701-51d1815248c3f. It was then passed for ethical
322 approval via Newcastle and North Tyneside 1 NRES Committee 2.4.2014, reference number
323 14/NE/0060, 7th April 2014. This study has an IRAS ID 135428.

324

325 **Funding**

326 This research did not receive any grant from funding agencies in the public, commercial, or not-for-
327 profit sectors.

Table 1
Participant demographics

Participant	Age	Gestation at interview (weeks)	Number of weeks with PPGP	Highest education qualification	Exercise hours per week	With a co-inhabiting partners
1	29	26	5	A-level	0	Yes
2	26	28	6	GCSE	0	Yes
3	22	21	10	Degree	1.5	Yes
4	27	22	8	NVQ	20-30	Yes
5	21	29	11	A-level	0	Yes
6	20	30	14	NVQ	0	Yes
7	24	28	10	A-level	0	Yes
8	27	21	8	A-level	0	No

Demographic data collected to remain comparable to existing PPGP studies [8,13,14,]

Table 2
Interview schedule

Main Questions	Probing Questions
What is it like to be pregnant?	Is it what you expected?
What does the diagnosis of PPGP mean to you?	Is pain the main problem?
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? (<i>Shown a PPGP outcome measure</i>)	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

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

Table 4

Codes that informed categories

Categories	Onset of PPGP	Impact on psychosocial	Expectations of PPGP	Healthcare experience	Support from family and friends	Treatment	Perceptions of others	Fear	Importance of Knowing	Looking up the problem	
Codes	Duration	Being pregnant	Expectations	Advice from medical professionals	Support from others	Successful treatment	How other women must feel	Worry	Not knowing	Looking up the problem	
	Onset	Not fun	Suitability of the PGQ outcome measure	Expectations of physiotherapy	Helplessness from significant other when trying to describe PPGP	Know about a treatment		Self-Doubt	Prior knowledge of PPGP	Knowing the seriousness of the problem	
	Process of diagnosis	Health	Preventative measures	Negativity from others when managing PPGP	Sympathy from others	Use of painkillers		I think I'd do it again for my baby	Original thoughts on what the PPGP was	Prior knowledge of PPGP	
	Description of symptoms	Sacrifice		Successful treatment	People being understanding	Impacts treatments have other than pain		Fear			Original thoughts on what PPGP was
		Impact on ADL's		Trust	Negativity from others when managing PPGP	Desirables		Lack of control			
		Psycho-physical impacts other than pain		Preventative measures	Reassuring			Coping until birth			Fear
		Social impacts									Worry and self-doubt
		Feelings of guilt									Not knowing
											Knowing others have had the same problem
											What do you want to know about a treatment

Table 5
 Categories that informed themes

The reality of PPGP	Key Mechanisms of Support	Impact of Knowledge
Onset of PPGP	Healthcare experience	Importance of Knowing
Impact on psycho-social	Support from family and friends	Looking up the problem
Expectations of PPGP	Treatment	Perceptions of others
		Fear

328

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