

“The ignored pain” - experiences of encounters with healthcare from the perspective of women with pain persisting after childbirth - a qualitative study

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ABSTRACT

Introduction: Although the prevalence of pain persisting after pregnancy or labour decreases with time, up to 35 % of women report pain 8 months to 12 years after childbirth. To prevent the development and reduce the impact of chronic pain, researchers and clinicians emphasize the importance of early diagnosis as well as timely and appropriate treatment. Previous studies have shown that when women with post-childbirth morbidities consult healthcare professionals during the first year following birth, their problems are often neglected, and they do not receive adequate treatment.

Objective: To explore how women with pain persisting for eight months after childbirth experienced encounters with healthcare.

Methods: A descriptive qualitative design with 20 face-to-face, semi-structured interviews. Data were analysed using inductive qualitative content analysis.

Results: “Pain ignored by healthcare” was identified as an essential theme and included four categories: “Questioned pain experience,” “Inadequate pain management,” “Lost in healthcare,” and “Insufficient post-partum care”

Conclusion: The women experienced that their pain was often not recognized or adequately treated, but instead ignored or trivialized. Recurring were descriptions of experienced knowledge gaps among the healthcare providers regarding pain and its management. There was an overall desire among women for a well-defined and well-functioning chain of care with better accessibility and scope.

Introduction

Chronic pain is defined as pain that persists for longer than three months, regardless of cause or type of pain [1]. This kind of pain may be caused by ongoing, long-lasting tissue damage but also by maladaptive structural and functional changes in the central nervous system that have been initiated by trauma or disease and that persist despite the inciting damage having healed. The most important risk factor for the development of chronic pain is the presence of acute pain or chronic pain at another site within the body [2,3]. Although pregnancy and labour are considered natural processes, they can lead to pain and tissue

trauma. Research has shown that up to 76 % of pregnant women experience back and/or pelvic pain at some point during pregnancy [2]. In addition, women may suffer from painful injuries during vaginal birth as well as tissue damage during caesarean sections [4]. Although the prevalence of pain with onset during pregnancy or labour decreases with time, studies have found that up to 35 % of women report pain 8 months to 12 years after childbirth [5–8].

The presence of pain persisting after childbirth may have a negative effect on women's well-being and quality of life [8]. Chronic pain conditions have physical, psychological, cognitive, and social consequences, such as limited physical activity, cognitive impairment and

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altered self-image [9,10]. Women suffering from pain persisting after childbirth are more likely to experience postnatal depression than those without pain [11]. Furthermore, pain can have a negative impact on mothers' ability to care for their children [12,13]. It may also lead to fear and anxiety about future pregnancies and to women giving up dreams of having a larger family [10]. In addition, pain that persists for a longer period of time has the capacity to be more complex in its pathophysiology and thus potentially more difficult to treat. To prevent the development and reduce the impact of chronic pain, researchers and clinicians emphasize the importance of early diagnosis as well as timely and appropriate treatment [3]. However, studies have shown that women with post-childbirth morbidities, including pain, often do not consult healthcare professionals during the first year following birth as they do not know which healthcare settings are available or believe that the morbidities are a natural consequence of childbirth, and will resolve spontaneously with time [14–16]. When women turn to healthcare, they experience that their problems are often neglected and they do not receive adequate treatment [9,16]. Maternity care in Sweden has been a subject of extensive research and development over the recent years. New guidelines and routines have been established, with particular focus on perineal tears [17]. However, it is worth noting that chronic pain after childbirth is not only caused by perineal injuries and there are still no official statistics regarding the incidence of less severe perineal trauma or levator ani muscles injuries. In addition, the proportion of caesarean sections has increased in recent years [18]. Furthermore, according to the latest reports, three out of ten women who experience physical problems related to childbirth, do not know where to seek professional support. Healthcare providers may also experience uncertainty in terms of where women should be referred [19]. In general, chronic pain diagnostics and treatment remains a challenge, both globally and in Sweden. Several healthcare systems, and healthcare professionals' barriers that hinder patients from achieving optimal pain management, have been identified. System-related barriers include a lack of clearly defined standards and pain management protocols as well as limited access to pain specialists. Healthcare professionals' barriers include inadequate knowledge and skills, lack of availability as well as lack of holistic perspective [20]. A deeper knowledge of women's experiences can fill knowledge gaps which may translate into improved quality of care. Therefore, the present study aimed to explore how women with pain persisting for eight months after childbirth experienced encounters with healthcare.

Methods and materials

Study design

To address the aim, this study employed a descriptive qualitative design. Data were collected through face-to-face, semi-structured interviews and analysed using qualitative content analysis according to the procedure described by Graneheim and Lundman [21,22].

Context of the postnatal care

In Sweden, the delivery hospitals are responsible for the woman and her child during the first week after birth [23]. According to new guidelines, midwives contact women by telephone during the first two weeks after birth to explore the need for further contact. Postnatal visits are preferably offered on several occasions, as needed, between 6 and 16 weeks after delivery [17]. Thereafter, the child healthcare service meets the parents during regular visits that mainly follow the child's health, development and living conditions, and the woman becomes an ordinary patient within the primary healthcare [23].

Recruitment

The informants were recruited from a cohort of women participating

in a prospective, multicentre prevalence study that investigated the incidence and characteristics of chronic pain eight months after childbirth ($n = 1171$) [7]. The participants had given birth at one of seven hospitals located in the capital of Sweden, Stockholm (with approximately 2.2 million inhabitants), and a medium-sized region Västmanland County (with approximately 260 000 inhabitants) [24]. The exclusion criteria were stillbirth as well as the inability to speak and read Swedish. For the present study, the women were eligible to participate if they reported any pain with onset during pregnancy or labour and still experienced at the time of the study, regardless of cause or localisation of pain. The follow-up period of eight months has been chosen to pass the dividing line between acute and chronic pain due to recommendations regarding duration of pain for research purposes [25]. All women who met the inclusion criteria and gave written (prior to the prevalence study) as well as oral (prior to the interviews) informed consent to be interviewed ($n = 195$) were divided into three groups depending on pain onset: (1) during pregnancy ($n = 106$), (2) during labour ($n = 53$) and (3) during both pregnancy and labour ($n = 36$) to obtain as much variety as possible in the material. A sample size of 20 women was considered to be sufficient to obtain saturation [26]. A random sample was selected in each group and the women were contacted by telephone by the first author (BM). After the 20 interviews had been conducted, three were not considered relevant to the study as the women no longer had pain or the pain had started before pregnancy, which is why another three women were included. By the seventeenth interview, the patterns in the women's experiences were recognised and the final three interviews confirmed the sense that saturation had been reached. The recruitment procedure is presented in Fig. 1.

Data collection

Data were collected during face-to-face interviews by the first author (BM) between June and November 2016. The interviews took place according to the women's specific situation and preferences (two at the woman's workplace, one at the researcher's workplace, and seventeen at the woman's private home). The interviews were conducted using a semi-structured interview guide developed by all co-authors after a literature review. To evaluate the interview guide, a pilot interview (not included in the analysis) was performed; however, no changes were required. The interviews were guided by the following main question: "How would you describe your healthcare experience in relation to your current pain situation?" Open-ended support questions were used when needed. The interviews had an average length of 32 min (15–56 min). Each interview was audio recorded and transcribed verbatim in an anonymized transcript.

Data analysis

Inductive qualitative content analysis was carried out [21,22]. In the inductive approach, no prepared theory is utilized in the analytical process [27]. The analysis was performed in a stepwise manner using the freeware Open Code 4.03 (Open Code). The transcription was read several times by the first author (BM) to achieve immersion and obtain a sense of the whole. All data were then imported to the Open Code. Thereafter, the meaning units were identified, condensed, and coded. Codes were then grouped and organized into categories describing different aspects, similarities, or differences, of the content. The categories were compared and either divided into subcategories or merged into a new category. At this stage, efforts were made to stay close to the manifest text. This process was carried out back and forth until a consensus was reached. Finally, the theme was constructed based on the content of the identified categories in a more latent manner. The first author (BM) was responsible for the analysis, but the results were discussed regularly by co-authors (SZ and SG) during the entire process and finally among all the authors until a consensus of understanding of the data was achieved. The final step of the analysis was identifying quotes

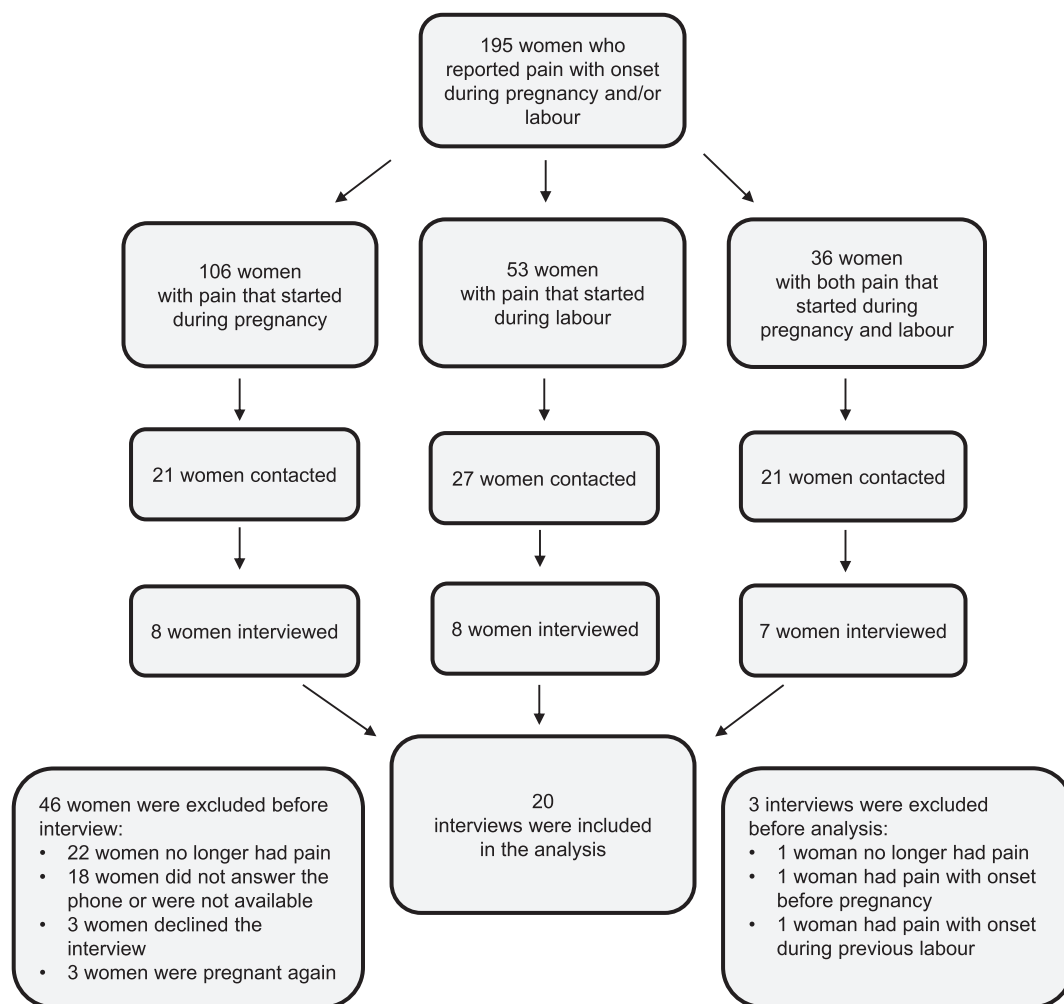


Fig. 1. An overview of the selection procedure.

for trustworthiness and exemplifying the content.

Ethical considerations

The study was approved by the Regional Ethical Review Board in Stockholm (Dnr 2015 / 236–31). The women were informed that participation in the study was voluntary and were assured that data would be treated confidentially. They gave both written and oral informed consent before the interviews.

Results

Characteristics of the participants in the in-depth interviews are presented in Table 1. The overarching theme “Pain ignored by healthcare” indicates poor recognition and management of pain persisting after childbirth. The women were often not asked about, or examined for, pain as well as they did not receive adequate treatment. In addition, the women experienced that they were not taken seriously, neither listened to, nor believed. When their pain was ignored or trivialized, especially when there was no visible cause for pain, the women felt diminished and stupid. The negative encounters with healthcare professionals also led to feelings of being insulted and humiliated. The women felt abandoned after the childbirth as the focus of the care shifted entirely to the baby, and they experienced being out of the maternity healthcare system. The women did not know where to find healthcare practitioner who could help them or did not dare to seek help which led to feeling of being alone. After living with pain for months,

they felt the urge to find help, however, most women were sent home without diagnosis or treatment. When some women eventually found a healthcare professional who provided support, validation, and empathy for their pain experience, they felt relieved and grateful. There was an overall desire for more support, accessibility, and continuity regarding care as well as better knowledge about pain and its management among healthcare professionals.

The theme was emerged and synthesised from four main categories: “Questioned pain experience,” “Inadequate pain management,” “Lost in healthcare,” and, “Insufficient postpartum care “. The theme, main categories and subcategories are presented in Fig. 2.

Questioned pain experience

Nearly all women visited a midwife for a postpartum check-up. In addition to this visit, during the first year after the childbirth, many women consulted several healthcare practitioners, such as other midwives, gynaecologists, general practitioners, physiotherapists, chiropractors and naprapaths. Recurring in women’s stories were descriptions that they were not listened to, understood, or taken seriously. Their pain was often ignored by health healthcare professionals as if it was non-existent or insignificant. For example, when they visited a midwife for a postpartum check-up, they were rarely asked about, assessed, or examined for pain. When the pain was mentioned by the women during an appointment, their complaints were often not acknowledged but instead belittled or trivialized.

She said that there is no point in even looking because now everything is so

Table 1
 Characteristics of the participants (n = 20).

Women	Age (years)	Time since labour (months)	Pain onset	Pain localization	Pain frequency	Delivery route	Parity	Country of birth	Educational level	Marital status
1	28	9	P + L	Head, ribs, pelvis	Constant	V	Primi	Sweden	CL	M/R
2	34	11	L	Os coccyx, in anus	Constant	V	Multi	Sweden	CL	M/R
3	36	13	L	Perineum	A few times a week	V	Primi	Sweden	CL	M/R
4	43	12	L	Abdomen, surgical site after caesarean section	Constant	CS	Primi	Sweden	CL	M/R
5	32	12	P	Pelvis, lower back	A few times a week	CS	Primi	Sweden	CL	M/R
6	25	9	L	In anus, lower back	Constant	V	Primi	Sweden	CL	M/R
7	36	10	L	Surgical site after caesarean section, abdomen, lower back, feet	Constant	CS	Primi	Sweden	CL	M/R
8	39	11	P + L	Lower back, abdomen	Constant	CS	Multi	Poland	USC	M/R
9	32	11	L	In/around vulva, perineum, os coccyx	Every day	V	Multi	Sweden	USC	M/R
10	40	9	L	Pelvis, lower back, abdomen	Every day	CS	Primi	Sweden	CL	M/R
11	41	11	P + L	Pelvis, perineum	Every day	V	Multi	Sweden	CL	M/R
12	27	13	P + L	Lower back, in anus	A few times a week	V	Primi	Sweden	USC	M/R
13	36	11	P	Pelvis, abdomen	Every day	CS	Primi	Mexico	CL	M/R
14	33	11	P + L	Pelvis, abdomen	Every day	CS	Primi	Chile	CL	S
15	31	12	P	Lower back, pelvis	A few times a month	V	Primi	Sweden	USC	M/R
16	38	14	P + L	In anus, lower back	Constant	V	Multi	Sweden	CL	M/R
17	31	14	L	Perineum, abdomen	Every day	V	Primi	Sweden	CL	M/R
18	28	12	P + L	Lower back, abdomen	Constant	V	Primi	Sweden	ES	M/R
19	35	14	P	Pelvis	A few times a week	V	Primi	Sweden	CL	M/R
20	27	13	P	Lower back	Every day	V	Multi	Sweden	CL	M/R

Notes. P: pain onset during pregnancy, L: pain onset in relation to labour, V: vaginal delivery, CS: caesarean section, Primi: primipara, Multi: multipara, ES: Elementary school, USC: Upper secondary school, CL: College, M/R: married or in relationship, S: single.

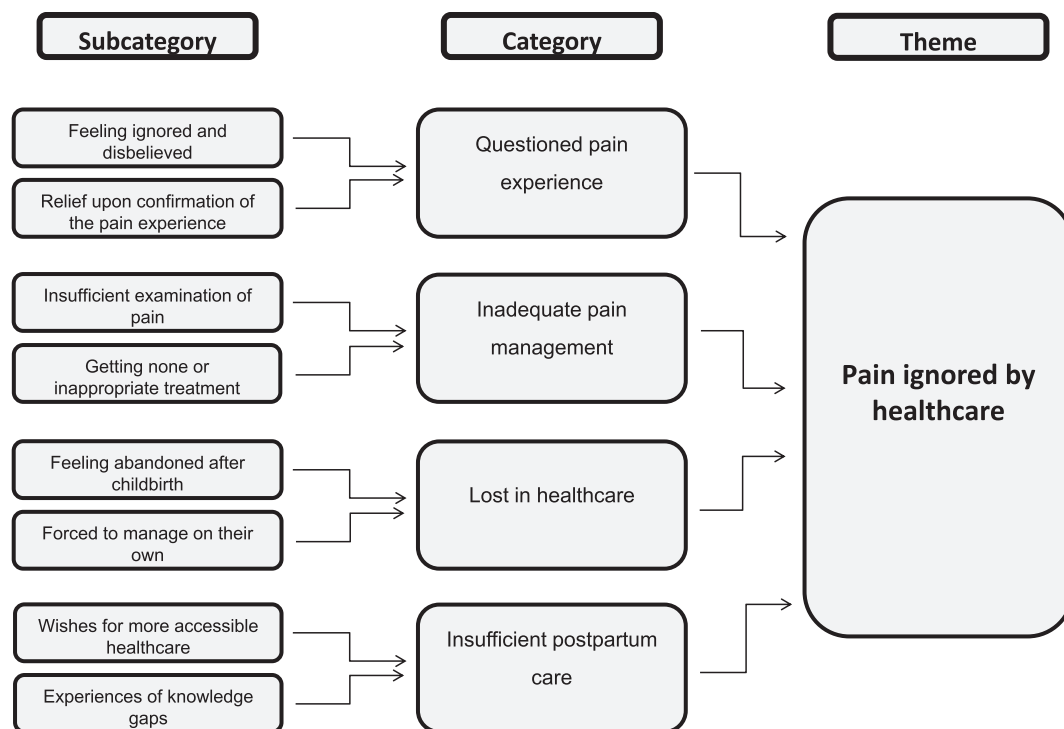


Fig. 2. An overview of the theme, categories, and subcategories.

swollen and so close [to the childbirth], so it can feel strange. She just talked to me and said, “But you can sit on a chair so then it’s okay”. (Multipara, 41-year, no.11).

In the narratives, some women expressed that they were not believed

and that their experience was questioned by the health professionals. For instance, those women, who suffered from pain caused by perineal trauma during birth, have often been told after an examination that their childbirth-related injuries seemed to have healed, and they were not

supposed to experience pain. Some of the women described being distrusted to the extent that they felt accused of lying or simulating pain, especially since there were no objective signs of trauma or disease. Having their own experiences questioned by healthcare professionals led to women believing that their problems were insignificant and could not be addressed. Furthermore, the dismissive behaviours violated the women's sense of dignity and credibility leading to them feeling insulted and humiliated. One woman complained that she felt that she was "treated like an idiot" by healthcare professionals.

You feel so stupid in healthcare. They were very right, and I was very wrong, it felt like that. Maybe they should have more of a discussion with patients and think that patients also have a brain. (Multipara, 41-year, no.11).

In addition, not being taken seriously or listened to led to several women feeling that they had lost trust in healthcare. Some of them even suggested that negative encounters with healthcare professionals greatly contributed to their problems or led to a postponed recovery.

Several women described a feeling of resignation and gave up seeking further help. However, some of the women continued trying and, in some cases, eventually met a healthcare professional who took them seriously and validated their pain experience as well as the need for treatment. When this happened, the women felt a sense of relief, safety, and gratefulness. Encounters that were characterised by validation and support could contribute positively to the woman's recovery.

And then, after I'd seen her twice, my problem was so much better. I'm absolutely fascinated, it has really, really helped. And pretty quickly from having pain every day to one or a few times a week. (Primipara, 36-year, no. 3).

Inadequate pain management

According to the women, even when their experience has been recognized and confirmed, they have often not received a diagnosis or explanation for the pain and were told that there was no treatment available. Instead, they were advised that they should accept the pain as a normal or inevitable part of the childbirth and that it should resolve spontaneously with time. In most cases, the women were sent home without further investigations.

They say there is nothing they can do about it [pain] but it will disappear by itself eventually, but no one can say how long it will take. (Primipara, 28-year, no. 18).

When treatment was recommended, it was often perceived by the women as general and not targeted at their specific condition. Some women received treatments that were ineffective or only effective to some extent. During a return visit to the healthcare practitioner, the women were often told that there is no more or other treatment available for their pain and they were not advised to seek further professional help or referred to other members of the healthcare team.

I sought help after three months and I got a cream and then I was prescribed laxatives, and then she told me that if it does not get better in six weeks, come back. So, I came back, and then she said there is nothing more she can do. (Primipara, 25-year, no. 6).

Several women reported that they had received conflicting diagnoses or treatment recommendations from different healthcare professionals. In the worst cases, the received treatment could even aggravate the problems or contribute to the condition becoming chronic.

And she [the chiropractor] said, "You should not be out walking at all, your pelvis is completely unstable." But then the damage was already done, and I thought I was good but I kind of ruined it. (Primipara, 40-year, no. 10).

Lost in healthcare

Through women's descriptions, there was an overarching story depicting feelings of being completely unprepared for, and overwhelmed by, the fact that they were so well taken care of during

pregnancy, but everything ended abruptly after the child was born. The women experienced that after childbirth the focus of the healthcare shifted to the new-born baby with little concern regarding the wellbeing of the mother.

When I was expecting a child, she [the midwife] was very concerned that I should see various doctors, be on sick leave, go to a physiotherapist and try to alleviate my pain, but when I had given birth, she said like this - you are out of our system now. You may come back when you are pregnant again. (Primipara, 33-year, no. 14).

The experience of suddenly being out of the maternity healthcare system could lead to a variety of negative emotions, such as sadness, anger, frustration, disappointment, and anxiety. The women felt abandoned, unseen and alone.

There must be measures and controls afterwards so that you can have a reasonably normal life even though you have given birth and are consumed... that's how it feels... (Primipara, 43-year, no. 4).

Recurring were also women's descriptions of being forced to find help and navigate the healthcare system completely on their own. They described attempts to identify treatment pathways as challenging and did not know where to find healthcare providers adequate in meeting their needs. Many women experienced that they were sent "back and forth" between different healthcare practitioners, sometimes as many as eight, most often without receiving help. This could be overwhelming and time-consuming. One participant, who herself worked in healthcare, expressed that women cannot count on much help and support from healthcare after childbirth.

Honestly, I feel like this is it. This is not a high priority topic. You have to find your own way (Primipara, 35-year, no. 19).

Insufficient postpartum care

Many of the women highlighted a lack of a well-defined and well-functioning chain of care that would make it possible to come to the right place directly and feel welcome there. They also pointed out that postnatal services should continue up to one year after childbirth. In addition, the women expressed a need for an opportunity of having multiple postpartum check-ups as well as an establishment of an easily accessible healthcare facility or clinic to which they could turn with their postpartum morbidities, including pain. At these facilities, women should be provided with ongoing support from various healthcare specialists, who collaborate to offer a more holistic approach to managing pain as well as other postpartum-related problems and concerns.

Some kind of follow-up program after, much like when you go to the maternity care centre before. And that it should be a little more customized. (Primipara, 36-year, no. 3).

Recurring themes in the women's stories were also descriptions of experiences of knowledge gaps and lack of competence among the healthcare providers regarding pain persisting after pregnancy and labour. This applied to the whole chain of care, different categories of healthcare professionals, and many aspects, including lack of pain assessment and management as well as inappropriate and unprofessional treatments.

They should be more knowledgeable or educated about it [pain] and not just like waving it away. They could know a little more, that it's not just about pelvic floor exercises. (Primipara, 35-year, no.5).

Lack of research in the field was also highlighted. The women participating in this study expressed great gratitude to the researcher because at least someone was listening and taking them seriously. Some of them asked the interviewer to publish the findings as soon as possible as they may raise awareness and knowledge among healthcare professionals about persisting childbirth-related pain.

Discussion

This study reports on how women with pain persisting for eight months after childbirth experienced encounters with healthcare. Our

results show that the women were often not examined for pain and/or they did not receive adequate treatment. This, together with the fact that approximately half of the women do not seek help for their condition [28], may lead to pain not being diagnosed or treated. This is in accordance with previous studies investigating experiences of women with enduring postpartum morbidities [9,14,16] as well as those with chronic pain conditions, such as fibromyalgia [29] or endometriosis [30]. Poor recognition and management of chronic pain related to childbirth can lead to extensive consequences. First, it is well-documented that pain has a profound negative impact on all aspects of women's lives including their roles as mothers and may lead to suffering and lower quality of life [9,10]. Second, if the pain is not timely diagnosed and adequately treated it can be transformed into a chronic condition [3,31]. In addition, lack of, or inadequate, management may lead to maintenance of chronic pain as it can become more complex in its pathophysiology over time and ultimately refractory to treatment [32]. Therefore, it is crucial for healthcare professionals to recognise pain and provide early, individualized and effective pain management, in order to prevent women's suffering as well as potential long-term health problems, particularly since it occurs relatively early in life. In our study, the women experienced that they have not been asked about, or assessed for, pain at the postpartum follow-up visit. However, according to recent recommendations in Sweden, the assessment of postpartum injuries, healing process, and pain should be included in the postpartum check-up [19]. We are convinced that check-up visit is an excellent opportunity for assessment of, and counselling on, pain. The implementation of these recommendations will enable the monitoring of women at risk of developing chronic pain, and is an important step in ensuring that women receive the care they need.

The women in our study felt dissatisfied and disappointed regarding encounters with healthcare professionals as they experienced not being listened to or taken seriously. According to studies, not being believed by healthcare professionals is common for many people who suffer from conditions that are lacking a visible cause, including chronic pain [33,34]. Our results showed that dismissive attitudes violated the women's sense of dignity and credibility resulting in feeling insulted and humiliated. This is in accordance with studies showing that not believing or rendering an individual's symptoms as trivial or psychological can have a negative impact on psychological well-being and self-image, including loss of identity, self-esteem, and independence as well as lead to social isolation and stigma [33–35]. Due to the invisible nature of pain and because it is a subjective and individual experience that is impossible to be demonstrated by objective methods, pain should be accepted as “whatever the experiencing person says it is, existing whenever he says it does” [36]. Healthcare professionals should accept the patient's experience with or without any evidence of disease or symptoms [33]. Furthermore, as we discussed in our previous study, the women need help and support from health professionals in their endeavour to cope with chronic pain [10]. Not feeling believed and focusing on trying to develop credibility is often why patients with chronic pain are not able to move forward in the process to adapt to living with and managing chronic pain [10,33]. An interested approach to pain, empathy as well as confirmation of the experience and need for treatment are also of great importance in the healthcare professional-patient relationship and for successful pain management [33].

The experiences of the women participating in the present study also indicate a concerning lack of knowledge about chronic pain among healthcare professionals. An example of this is that the pain has often been dismissed because of no objective signs of tissue trauma or disease. However, according to current knowledge, chronic pain develops as a consequence of maladaptive and functional changes in the central nervous system [3]. These changes persist beyond the usual recovery period of the trauma and lead to an experience of pain despite the initial injury having healed. In chronic pain, there may still be a peripheral generator of the pain, but in most cases the changes in the central nervous system are the only cause of pain [3]. Furthermore, the women have often been

informed that it is “normal” to have pain after childbirth and that it will disappear spontaneously with time. There seems to be a widespread opinion that pain is a natural part of the postpartum period, and it appears not to be seen as an ailment or disease [14,28]. However, in medical assessment, pain should always be recognized as a symptom that indicates something deviating. Therefore, there is a need to investigate possible knowledge gaps and provide healthcare professionals with support regarding up-to-date education as well as guidelines and recommendations.

In Sweden, postnatal follow-up care for new mothers is limited to 16 weeks after childbirth. However, as previous studies have shown, childbirth-related pain can persist up to years postnatally [5,7,8], indicating that the postnatal recovery time may be longer than the presumed 16 weeks. Thus, we suggest that more long-term postpartum care support is needed. This is also in line with women's wishes regarding continuity, as shown in our results. Our study also indicates a need for well-functioning healthcare structures that enable the management of pain persisting after childbirth to which women can turn or be referred to when they need help with their pain-related problems. Because of the complexity of chronic pain and its management, it would be preferable to have a multidisciplinary approach, with midwives, obstetricians, general practitioners, physiotherapists, and psychologists working in teams who can provide comprehensive physiological and psychological support for the women.

Methodological considerations

There are four aspects in assessing the trustworthiness of qualitative research: credibility, dependability, confirmability, and transferability [22,37]. Credibility refers to the extent to which the research addresses the aim [22]. Given the scarcity of previous research, the inductive approach may strengthen the credibility of the study as the findings were derived from the women's narratives. We used a semi-structured interview guide which was developed within the research group and validated in a pilot interview to ensure it was suitable for obtaining rich data that addressed the aim. Credibility was also ensured by the data analysis being performed by the first author (BM) in close collaboration with two other authors (SZ, and SG) who held regular meetings during the whole process. Furthermore, all research group members, with different professional and research perspectives, discussed the results until the interpretation which best represented the meaning of the data was found. Being a midwife and a pain educator, the first author (BM) had a preconceived knowledge of the subject studied necessary to capture important nuances in the data that otherwise may be lost, but also may be a threat to both credibility and confirmability. However, by being self-aware as well as using reflexivity [38], the author tried to avoid influencing the informants and the results with her own opinions. In addition, the involvement of co-authors counterbalanced this pre-understanding. A purposive sampling was used to recruit responders who could provide in-depth and detailed information about the phenomenon studied. The concept of data saturation was used in effort to yield a rich material. Although a preliminary analysis of the collected data was not performed, by the seventeenth interview patterns of the women's experiences were recognized, and the three final interviews verified that saturation was obtained. This was also confirmed during the analysis of the data. However, the recruitment of participants in our study did result in the under-representation of single women and women with a lower educational level. Furthermore, due to the inclusion criteria, only three of 20 women were foreign-born with a non-Swedish speaking background. This constitutes approximately half of the total of foreign-born mothers in Sweden (27.5%) [4]. This under-representation limits the extent to which these findings can be transferred to other settings or populations [38]. In addition, including more women from ethnic minorities might also have provided a different perspective and should be investigated in future studies. At the same time, our findings to some extent confirmed the findings of previous studies even though

the knowledge is limited. Moreover, to strive for confirmability, credibility and to create a basis for assessment of transferability, quotations were used generously in the study to illustrate and reflect each of the central aspects of the categories and subcategories. In addition, the research process has been thoroughly described [22,38].

Conclusions and implications for practice

Our results show that when the women with pain persisting after childbirth turned to healthcare, they experienced that it was often not recognized, assessed, or adequately treated but instead ignored or trivialized. The women felt alone and forced to navigate the healthcare system on their own. There was an overall desire for a well-defined chain of care with better accessibility and scope. Descriptions of experienced knowledge gaps and lack of competence among the healthcare providers regarding pain and its management were recurring.

Because of the negative consequences, pain recognition and management should be considered a priority, and healthcare professionals should be proactive in preventing the development of chronic pain. Recommendations for future practice include implementation of routine assessment of, and counselling on, pain during postpartum check-up visits, more comprehensive and accessible postpartum care, and a multidisciplinary approach regarding management of pain. In addition, there is a need to investigate possible knowledge gaps regarding educational programs, continuing education as well as knowledge support, in the form of guidelines and recommendations at national level.

Ethical statement

Ethical approval was obtained 2015–03-04 from the Regional Ethics Review Board in Stockholm (Dnr 2015 / 236–31). The participants obtained both verbal and written information about the study. They were informed that participation was voluntary and were assured that data would be treated confidentially. The participants gave their written and verbal consent both to the quantitative and qualitative data collection.

Consent for publication

Not applicable.

Availability of data and materials

The data used and/or analysed during this study are not publicly available since participants did not give consent for public sharing of their information and have been promised confidentiality. The data collected is protected by confidentiality in accordance with The Public Access to Information and Secrecy Act (SFS 1998:204) and is handled in accordance with the Personal Data Act (SFS 1998:204), which means that no unauthorized person may access the information (Ethical approval, Dnr 2015 / 236–31).

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Declaration of Generative AI and AI-assisted technologies in the writing process: during the preparation of this work the authors did not use any AI and AI-assisted technologies.

Declaration of Competing Interest

The authors declare that they have no known competing financial

interests or personal relationships that could have appeared to influence the work reported in this paper.

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