

# Understanding pregnant women's experiences of symphysis pubis dysfunction: the effect of pain

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## Abstract

**Background.** Symphysis pubis dysfunction (SPD) is an abnormal stretching of the pubic joint in pregnancy, which causes distress and pain during and after pregnancy. Measures of its incidence varies widely, and most research has focused on identifying causes. Among healthcare professionals, there is evidence of low levels of awareness of SPD and a lack of sympathy toward women with it.

**Aim.** To explore women's experiences of SPD during pregnancy and up to six weeks postpartum, with particular reference to pain.

**Method.** A qualitative, phenomenological approach was used in conducting semi-structured interviews in a large maternity hospital in the north-west of England. A total of 28 women were interviewed during pregnancy and six weeks postpartum (51 interviews).

**Findings.** The dominant theme to emerge was the women's experiences of pain. Pain was described in compelling language, and some women overdosed themselves on analgesics. Pain was sometimes accompanied by sounds that were audible to others. Living with SPD was problematic in every case, and recommended management for the relief of pain brought little benefit to the women. Most women found coping difficult, felt a burden to family and friends and in some instances feared for their mental health.

**Conclusions.** SPD can have a devastating effect on women. Midwives and other healthcare professionals have a duty to take the condition seriously. More research is needed to ascertain cause, to identify more effective pain relief, and most importantly to raise awareness of SPD and increase information and support.

**Key words:** Pain, symphysis pubis dysfunction, coping strategies, isolation, helplessness, chronic pain, pelvic pain

## Introduction

Symphysis pubis dysfunction (SPD) may be defined as an abnormal stretching of the pubic joint during pregnancy (Wellock, 2002). It is a distressing and painful condition that affects women during pregnancy and the postpartum period. Signs and symptoms may include tenderness of the symphysis pubis, groin pain radiating to the inner thigh, increased pubic pain during normal activities such as walking, parting or lifting the legs, a waddling gait, and difficulty turning over in bed, abducting the legs or getting dressed. The normal physiological non-pregnant symphysis pubis gap measures from 4mm to 5mm. Separation of more than 5mm but less than 10mm may be termed SPD (Heyman and Lindquist, 1932), and can be confirmed by x-ray or ultrasound scan (Lindsay et al, 1988).

The measured incidence of SPD varies considerably, from 1:521 to 1:20 000 individuals (Boland, 1933; Lindsey et al, 1988). These figures are from studies conducted over a broad time span and in countries with different cultures, healthcare systems and methods of data collection. In addition, lack of clarity in the definition of SPD means that old statistics may be unreliable. Some previous quantitative research undertaken to diagnose the condition used invasive methods such as a triangular cardboard tube with metal markers that could be seen on x-ray strapped to the skin over the symphysis (Heyman and Lindquist, 1932). X-rays were performed early and later in pregnancy, but this is now known to be detrimental to the fetus (Wagner et al, 1997).

A specific cause for SPD has not been identified, but theories include genetic or environmental factors (MacLennan et al, 1997). The hormone 'relaxin' is widely suggested as the main antagonist, but this is unproven (MacLennan et al, 1986; Kristiansson et al, 1996; Bjorklund, 2000; Jain et al, 2006).

In England, Mason et al (2000) found an incidence of 1:36 women in a large maternity hospital in the north, while Wellock (2002) found an incidence of 1:27 at another large maternity hospital in the North-West.

A literature search was undertaken using the databases MEDLINE, Cochrane Library, CINAHL, MIDIRS, British Nursing Index and Evidence-Based Medicine Reviews. Key words used initially included 'pubic symphysis', 'abnormalities', 'anatomy', 'physiology', 'injuries' and 'ultrasonography'. Results were narrowed down to 57, first by adding the terms 'human' and 'English language', and then the term 'pain'. In order to relate experiences of pain from SPD with those associated with other conditions, a second search was conducted using the key words 'pelvic pain', 'audible sounds', 'analgesia', 'pelvic supports', 'isolation', 'helplessness', 'relaxin', 'fibromyalgia', 'gender pain', 'metaphor' and 'story telling'.

Historically, several authors (Snelling, 1870; Barnes, 1933; Young, 1940) refer to women's inability to care for their children – chiefly to inform other experts of a possible reason for this 'malady' in women – and state that others had

previously reported the condition, with case studies involving recognisable symptoms. This made it easier to identify with the symptoms presented in this study and that SPD has been recognised in the past and throughout Europe.

Prior to the definition of the term SPD (Polden, 1995), the names used to describe it included 'relaxation of pelvic articulations' (Snelling, 1870), 'sacro-iliac relaxation' (Meisenbach, 1911), 'relaxation of the pelvic joints' (Abramson et al, 1933), 'separation of the symphysis pubis' (Boland, 1933), 'pelvic and dorsal insufficiency' (Genell, 1949), 'pelvic arthropathy' (Driessen, 1987) and 'pelvic girdle relaxation of pregnancy' (MacLennan et al, 1997).

Studies, particularly from Scandinavia have concentrated on causes of SPD rather than women's experiences of it (Kristiansson et al, 1996; Albert et al, 1997; Larsen et al, 1999; Bjorklund et al, 2000). While causation is important, how women feel about the condition may help midwives to support them more effectively. In more recent studies, women reported that healthcare professionals were unaware of and unsympathetic toward the effects of SPD (Hattersley, 2002; Akrigg, 2003; Whitby, 2003; Raheem, 2003).

Owens et al (2002) used a postal questionnaire that was sent to participants of a previous study by Mason et al (2000), in which all of them had been diagnosed as having SPD. Of 248 questionnaires sent to women to collect information on their perception of the pain of SPD and treatment offered, 141 women responded. In what was described as a 'recurrent theme' (Owens et al, 2002: 144), an unspecified number stated that they felt ignored by staff when they complained of pain, and that staff did not appear to take complaints of pain seriously and demonstrated a lack of knowledge about SPD.

Shepherd (2005) used a phenomenological, Heideggerian hermeneutic methodology to explore women's experiences of SPD. Midwives and physiotherapists referred women with SPD, providing a purposive sample of nine women, and Shepherd identified four themes – pain, emotions, lifestyle adaptation and lack of support and information from healthcare professionals. Women reported pain from ten weeks of pregnancy with some suffering up to 40 weeks' gestation. Pain affected all aspects of their daily lives, particularly turning over in bed and obtaining restful sleep, since no analgesics eradicated the pain. The women reported feelings of fear, anxiety and guilt. One particular fear related to the impact that SPD may have on labour and delivery, with two women choosing to have a caesarean section (Shepherd, 2005).

Management of the condition is poorly researched and could benefit from detailed study. The only analgesic recommended in pregnancy is paracetamol, although overdose can cause fetal hepatic toxicity (Roche and Hughes, 1999). Codeine and morphine derivatives are thought to be teratogenic to the fetus and are not recommended in pregnancy (Mims, 2004). The only physical aids available for women with SPD are pelvic supports that are fitted by physiotherapists with instruction for women on how and when to use them. Fortunately, women do find a gradual reduction in symptoms of SPD between six and eight weeks postpartum.

Many women view pregnancy with happiness, and pregnancy will be uneventful in the majority of cases (Green et al,

1998). Expectations of motherhood are still associated with joy and fulfilment, and this may be a reason why negative views tend not to be voiced during pregnancy and childbirth (Hall and Papageorgiou, 2005). However, pregnancy can be a stressful and emotional period of life, and women do worry about many aspects of the pregnancy, the baby and their own health (Homer et al, 2002).

Better understanding of SPD from the women's point of view and how it affects their lives is likely to increase knowledge and understanding among healthcare professionals.

### Aim

The aim of the study was to explore pregnant women's experiences of SPD and its effect on their quality of life during pregnancy and up to six weeks postpartum. In particular, to explore how women were diagnosed, treated and managed by healthcare professionals.

### Method

The nature of the research question was to focus on the individual and personal experience of women with SPD. This concept was thought best suited to the phenomenological approach devised by Husserl (Maggs-Rapport, 2001). However, because Husserl believed that the researcher had to 'bracket out' – to set aside all presuppositions and preconceived ideas about what was being researched in order to view the experience more accurately – it became evident that the Heideggerian approach would be more effective. This approach was chosen to capture the 'lived in' experience for each woman (Heidegger, 1975) and of 'being in the world' of the person who is experiencing the issue under research (Heidegger, 1962). The topic of whether or not to bracket is subject to controversy. It is considered essential in some research traditions (Polit and Hungler, 1999), although Somers-Smith (2001) and Parahoo (2006) state that it can be a problem for the researcher to disengage from known practices. Taylor (1995) argues that previous experience can only enhance knowledge gained from the participants, who freely discuss their feelings about being in the world. The researchers acknowledge that Heidegger preferred the interpretive method when dealing with the findings of the research. However, on listening to the women, the researchers felt it was important to stay true to their actual words in order to answer the question 'what is it like?' and to describe rather than interpret their experiences. This led to the use of a descriptive method of data analysis (Colaizzi, 1978).

### *Data collection*

Data were collected by audiotape and in-depth interviews, which took place in the women's homes at their request because of the difficulties in mobilisation many experienced going to antenatal clinics. The interview method was chosen because the researchers wanted the women to feel free to talk about the phenomena from their perspective. The focus was primarily on the women's experiences, so questions related to their experience of living with the phenomenon of SPD (Cluett and Bluff, 2000; Polit and Beck, 2006). Limitations of this method are that the researcher cannot direct the conversation or ask

predetermined questions but must listen carefully, making sure that the conversation is relaxed and flows well (Cluett and Bluff, 2000). Interviews were planned to take place at initial diagnosis, 36 weeks' gestation and six weeks postpartum, between March 2003 and February 2005. However this was not possible with all participants, due to late diagnosis or referral, or because women were hospitalised at those time points. Parahoo (2006) suggested that 30-minute interviews are too short to achieve detail and that two hours is too tiring. The majority of interviews in this study lasted about 60 minutes.

The key overall question that was asked of women was: 'Tell me about your experiences of living with SPD during your pregnancy and after childbirth.' In an attempt to reduce bias, the researchers studiously avoided use of the word 'pain', only using it when the women used it themselves.

### Sample

The sample was a purposive or purposeful one – only women diagnosed as having SPD were invited to join the study – as is common in qualitative sampling (Holloway, 1997). Women with a probable diagnosis of SPD were referred by midwives or doctors to the physiotherapy department of a large maternity hospital in north-west England. Physiotherapists were requested to assign women to one of four categories of SPD – mild, moderate, severe or other – so that a range of symptoms could be explored. The physiotherapists confirmed diagnosis and assigned the category. This method of categorisation was thought to be useful by the researchers in order to assess different levels of the condition, but the physiotherapists found it to be cumbersome and it was not referred to again after the study. It was envisaged that 20 women would participate, five from each category, but that more would be included if saturation had not been reached. Inclusion criteria were pregnancy, a diagnosis of SPD by the physiotherapist and a willingness to give written consent to participate. Exclusion criteria were miscarriage and fetal death.

### Ethical issues

Ethical approval was obtained from the local research ethics committee and the university and hospital research and development committees. Prior to each interview, women were asked for their written consent forms, and this was recorded on tape. The women were assured of confidentiality and privacy, and the researcher assured them of anonymity prior to each encounter, which was also recorded on tape. They were told that the tapes would be stored securely and destroyed after transcription and completion of the study. Participants were informed that they were free to opt out at any time without their treatment being affected. They were given a specific information sheet outlining the study, and this was followed by a telephone call from one of the researchers to answer any outstanding queries.

### Data analysis

All interviews were transcribed verbatim. Analysis was informed by the phenomenological tradition, using Colaizzi's (1978) seven-step approach:

- Collection of data from participants
- Detailed examination of interview transcripts
- Extraction of phrases directly related to the phenomenon
- Consideration of the meanings of these phrases
- Extraction of themes from interpretation of the phrases
- Themes become a description of the phenomenon
- Return to participants to check for trustworthiness.

Emergent themes and subthemes were identified, explored and discussed fully by the researchers and the seven steps followed carefully. The extraction of phrases and consideration of their meanings involved the researchers attempting to understand what was said by the participants, and when themes emerged, confirming these findings with the women themselves. When the transcription was concluded and reflected upon, participants were again asked to confirm the accuracy of the work. One participant asked for a remark she had made about a relative to be removed because she wanted to keep the transcript, which was done.

### Findings

A total of 28 women were recruited with no refusals or withdrawals, resulting in 51 completed interviews. The women's ages ranged from 17 to 42 years, and there was a wide range of parity from primigravida to para five. The ethnic mix was diverse, as was that of the local area, and although English was not the first language for 30% of women, none required an interpreter. Three women were interviewed at all three time points, and 17 were interviewed twice. Eight women were only interviewed once because they moved out of the area to live with relatives, did not deliver until after the study or were diagnosed too late in pregnancy. Time of diagnosis varied from 18 to 38 weeks' gestation, as there was some difficulty in obtaining physiotherapy appointments (where the condition would be diagnosed).

The most dominant theme to emerge was the women's experiences of pain, its severity and sounds accompanying it that were audible to them and others, which will be the focus of this paper. Two other themes – impaired activities in multiple aspects of life and interaction with healthcare professionals – will be dealt with elsewhere.

The experience of pain was voiced in many ways, impacting on daily activities and on their interactions with family, friends, colleagues and healthcare professionals:

*'Finally [I] got to the stage where I couldn't cope... if I can't look after myself, how will I cope with my son and new baby? I'm a burden on my husband and family and don't want to be looked after'* (VM11).

The women demonstrated their pain verbally and non-verbally, using altered facial expressions and demonstrating body movements. Many displayed emotion when recollecting pain, and while the researchers occasionally spoke of 'discomfort', the women were consistent in using the stronger descriptor of 'pain' even when diagnosed as having mild SPD.

### Women's perception of pain

Pain was described vividly using compelling language that linked it with an actual injury, such as 'throbbing', 'stabbing', 'prodding', 'raw', 'sharp', 'pointy', 'poking'.

Several women used metaphors and simile. Two described a feeling of being 'raw' on the inside and their facial expressions changed as they talked about how it made them feel:

*'It felt raw, as if I was being sand papered... all the muscles and everything'* (VM11).

*'My whole pelvis feels raw, I wish it were possible to apply a lubricant to the inside of my pelvis and bottom of my spine so that it wouldn't grind... it is the inside I wish I could reach'* (VM38).

Several women used metaphors such as 'cheese wire' to describe the sensation:

*'Sometimes I get the cheese wire feeling... at the top of my leg... it's like you need oilings'* (VM25).

*'I feel that I have a piece of wire... cheese wire, stuck around me... the groin area... it feels like something's lodged there'* (VM9).

One woman described the pain as uncontrollable, which gave her a feeling of losing power:

*'The bone area... I thought it was going to break... all I know is I couldn't control how much pain... I couldn't hold it in... It was more like two bricks rubbing... it sounds weird... you know two bricks rubbing... from the inside of your bum, everything is going to split out'* (VM47).

Many of the women also experienced sounds when they mobilised. This came to light when they were talking about sensations of pain that commonly occurred from midway to the end of the pregnancy. Words used to describe this included 'crunching', 'crack', 'crunch', 'clunk', 'cracking pain', 'clonking' and 'click'. Hearing such noise was worrying for some, and at times it was loud enough to be heard by others. It appeared that such sounds acted as a proof to partners and others that the pain was real:

*'You can hear it clink, I've heard it clink a couple of times... whenever I've been around shops... I was clinking... my husband has heard it too... it takes your breath away'* (VM13).

*'So, I've been getting a bit of crunching after my walks... I've been a bit sore... I hear the crunch, my partner has also heard it... it's like a crack'* (VM25).

*'Getting up in the middle of the night if my son wakes up... I have to let it crack. I have to lie on one side... because there is no way in the world without excruciating pain and a great big clunk... that I can lie the other way... when I get out of bed, they all crack and there is a cracking pain and my legs go'* (VM44).

#### *Coping with and management of SPD*

For many of the women, paracetamol was considered the only recommended analgesic to be used during pregnancy. However, other drugs were also prescribed in order to reduce pain. Some women were reluctant to take medication as a result of worrying about detrimental effects for the fetus, and tried not to use anything. Others found paracetamol ineffective:

*'The consultant gave me codeine... I could take them if I lived on my own and hadn't got a child to care for... they make me feel sick and dizzy... I take [paracetamol] but nothing seems to work'* (VM44).

*'I was told to take paracetamol for the pain which I do... but it didn't make an awful lot of difference to... you know... the amount of pain I was in'* (VM32).

Pelvic supports to help control or manage the pain were ordered and fitted by the obstetric physiotherapist in the antenatal clinic of most hospitals. Very few women found the support helpful except perhaps initially:

*'The brace... yes... it can lift the baby's weight a little from me, and I am using the crutches also when I go outside'* (VM3).

The majority of women found the pelvic support uncomfortable because it tended to roll upwards and the Velcro caught their skin and caused rubbing and irritation. Some complained that it started off contractions early in pregnancy and that their babies did not like the belts:

*'[I] was given a brace. It's uncomfortable and the baby doesn't like it either... kicks against it... rides up an awful lot'* (VM14).

*'[I] found the brace more uncomfortable than anything else to be honest... I found it easier to hold my belly and walk around'* (VM36).

Other women opted for a combination of analgesics and the belt because they found it so hard to cope with the pain:

*'I was having [tramadol hydrochloride] and co-codamol at the same time as the brace because that is how much pain I was in... for three or four weeks I just lived off painkillers... I was taking eight of each as well. I might as well have taken Smarties... that's how it felt'* (VM47).

Additional ways that the women managed their own condition included planning all events beforehand, with some women planning their day with precision. Many methods were employed, such as timing getting out of bed, allowing more time to get to places, taking smaller and more frequent steps and remembering not to lift the legs sideways or lifting legs to climb over a child safety gate. Women learned to be as versatile as their condition would allow:

*'I was compensating by walking differently because I was bigger... it was incredibly painful to do anything... I have to know where I'm going to be... so I can judge if there's going to be somewhere I can sit down'* (VM32).

*'You have to plan which way would I have to move... where it hurts least'* (VM35).

Another method the women employed to try easing the pain, particularly in bed, was the use of pillows. Many slept with two or three pillows between their legs in a sideways position. Large bolster-type pillows were also used because they were more supportive, and some fitted pillows against their backs in an effort to stop themselves turning over during sleep:

*'It's fun with ten pillows in the bed beside me'* (VM33).

*'Well, I sleep on my side with the top of the pillow underneath my legs... it's comfortable, but you can't stay like that... you turn over and it's the pain'* (VM29).

Women had to rely on help and support from family and friends. For those with partners, support was readily available, but those without a partner found it hard to have to rely on friends and neighbours.

Some women's experiences caused the researchers concern, particularly in relation to their mental health. The behaviour exhibited was at times distressing, particularly when one woman at 23 weeks' gestation communicated to the

researchers by email that she intended to kill herself because she could no longer bear the pain (only one woman used this method of communication). Another felt driven to draw attention to her problem through an angry and loud threat to self harm unless the doctors ended her pain by performing a caesarean section. In the postnatal interview, two women admitted to taking twice the prescribed dose of analgesics during pregnancy. All of these women had been categorised as having severe SPD. In line with their responsibilities as practising midwives (NMC, 2004) and with her permission, all resources were called upon to support the woman who had expressed suicidal feelings. This included GPs, a community midwife and a pain clinic nurse. The researchers contacted the local research ethics committee to discuss removing this woman from the study, but she did not want to be removed and consented for her information to be used in the hope that it might help people to understand the condition. This situation was serious and distressing for all involved, and an entire paper could be devoted to its implications. While beyond the scope of this paper, the authors stress that the outcome for this woman was favourable.

#### *Living with SPD*

The pain of SPD affected all aspects of the daily lives of the women profoundly:

*'It stopped me shopping, lifting, and just everything really that I took for granted... that I could do beforehand'* (VM6).

This had a very negative effect on the women's ability to care for the home, their family and themselves:

*'Vacuuming, picking up a basket, the children, getting in and out of the bath, getting out of bed, going up the stairs. Everything ends up hurting and as the day goes on it gets worse and worse'* (VM16).

*'I felt really down at first when I got the experience because I thought I was useless around the house because I couldn't do anything for myself... I really felt down in myself'* (VM30).

*'The stairs? I don't... I just walk and open the door when [the child] goes to the toilet... I had a week in my clothes, I just could not get upstairs'* (VM3).

Women felt incapacitated, not only because they could not fulfil home activities, but also because they felt that they could not care for their children. This related to taking them to and from school in particular, primarily due to the inability to walk far or to get in or out of the car:

*'But getting out of the car and in, it's like hell... my little one wants me to pick him up... I can get one leg in, I can't get the other'* (VM30).

*'Getting in and out of the car is quite painful... I just remember being in excruciating pain... I can't drive, I can't get in the car'* (VM35).

*'I just noticed I couldn't go to school and pick up the children so I had to get taxis and everything... I couldn't go out'* (VM16).

Women's relationships with husbands or partners also changed. In nearly every case, husbands and partners were entirely sympathetic and supportive. However, they needed to help more in the home, and this become problematic in some instances:

*'With him [the son] being little, he wants me to do things, well... I can't sit down because it's uncomfortable and he wonders why isn't mum doing it, and dad is... [becomes very emotional at this point and cries]'* (VM30).

*'It affects your relationship with your partner. I am lucky, I've got a wonderful husband. It's all very well saying don't abduct your legs... but, when you make love you can't help it... I'm in so much pain... and even after we make love, I'm really in a lot of pain. We haven't made love for quite a while'* (VM19).

#### **Discussion**

The reactions described by some women in the study fit with aspects of chronic rather than acute pain. Chronic pain is classified as pain lasting for more than six months (Savidge et al, 1998; McGowan et al, 1999), although it has recently been suggested that this should be reduced to three months (Singh et al, 2005). Using these revised criteria, women with SPD could be described as having chronic pain, particularly since the pain can start early in pregnancy and continue for weeks or months.

The most profound finding in the study was that of pain, which impacted on every aspect of the women's lives. In some cases, it was a 'noisy' pain that could be heard by others at different stages of pregnancy. These and other findings prompted a further literature search in an effort to explore conditions that may have revealed similar themes.

In Wenof and PaulPerry's study on chronic pelvic pain, women reported a loss of physical activity and altered emotions – they felt displaced from their usual role as wife and mother (Wenof and PaulPerry, 1999). During pregnancy, women do not expect to experience pain, tending only to be concerned about the prospect of pain in labour (Lavender et al, 1999). The pain of SPD arises early in pregnancy for some women and it has been argued that this could influence their satisfaction with the birth experience (Lavender et al, 1999; Cronin, 2003; Ayers and Pickering, 2005). Pain is a highly individual sensation (Suchdev, 2002), but its various descriptions can help healthcare professionals understand its impact on the sufferer. The International Association for the Study of Pain (1994: 209) defines pain as 'an unpleasant sensory and emotional experience associated with actual or potential tissue damage or described in terms of such damage'. The women in this study described their pain in several ways, and many of the words used by them can be found in the McGill Pain Questionnaire (Melzack, 1987). This scoring system is used to help patients describe their experience subjectively and is well respected as a tool to assess levels of pain (Dudgeon et al, 2005).

Cook and Gordon (2004) found that the significance of the words used by people to express their feelings generated meanings by which they could personally make sense of what was happening to them. The use of metaphor and simile enrich the narrative and help to uncover meaning (Cook and Gordon, 2004). Leary (1990) describes a metaphor as giving one thing a name or description that belongs to something else on the grounds that there is some similarity between the two. Danziger (1990) found that a metaphor demonstrated a

thought in the mind in speech. Others suggest that the use of metaphor is a practicable way of expressing a notion in an interesting and understandable way (Fowler, 1996; Froggatt, 1998). Metaphor and simile add a great deal to the story of each woman. For example, 'sandpapering' suggests smoothing something rough, grating, rasping or coarse. It gives a more in-depth picture of a woman's experience and enables visualisation. Another woman described the wish to oil the inside of her pelvis. This reflects the grating pain and subsequent muscular spasm caused by weight-bearing. In a study in New Zealand on pain problems in pregnancy, Roche and Hughes (1999) stated that weight-bearing produces movement at the symphysis pubis. They reviewed the support and management of women with a variety of causes of pain in pregnancy with a view to helping doctors make good management decisions. The team were worried in case women felt unsupported by their doctors and went on to use inappropriate drugs, as this may lead to maternal and or fetal morbidity (Roche and Hughes, 1999). In this study, women told their stories because they wanted to be understood and to find some meaning in what was happening to them. This has also been expressed clearly in work by Savidge et al (1998), where respondents felt a need to tell interviewers how much this condition hurt them. Gaydors (2005) calls these stories 'self stories' – narratives of individual experiences, illustrating what it means to each person. Midwives are often in a privileged position during pregnancy and delivery, as facilitators in a profoundly intimate period of a woman's life. Women often share these experiences with their midwife, particularly when they have built up a relationship with them over time. Gaydors (2005) suggests that by the use of metaphor and simile, midwives can find the meanings behind the 'stories', but they must listen carefully. Banks-Wallace (1999) believes that storytelling is a way of understanding the 'personhood' of women. Midwives must therefore recognise that storytelling is particularly useful in SPD as the pain experienced by women is intense and substantially affects their quality of life.

An important finding was the confirmation and relief gained by others hearing noises from the pelvis. The sound was perceived to be the marker or proof that declared the truth or validated that the women's pain was real and tangible. In studies of patients with chronic low back pain, fibromyalgia and chronic fatigue syndrome, Chew-Graham and May (1999) and Asbring and Nanvaren (2004) found that participants developed a variety of strategies to gain control over their pain, including interactions with caregivers such as making demands or being demonstrative because they wanted them to 'do something'.

When trying to cope with the severity of the pain, the women reported that there were only two options available – analgesia and pelvic support belts – and that neither was particularly helpful. Many were reluctant to take any medication at all, but as the pain intensified they found it more difficult to refrain and often ended up taking more than the recommended dose. Several women admitted during the final interviews that they felt guilty for taking analgesia 'like Smarties' during the latter part of pregnancy and had prayed that the baby would be alright. The pelvic support belts were all of one design when the

study started. Few women felt that they were helpful beyond the initial stage of the condition, and in a short time they became positively uncomfortable. Women tended to devise their own methods of coping, using strategies they may have used previously or that were suggested to them by midwives, physiotherapists or friends. Pillows were a favourite, used to create and maintain an artificial space between the knees. They were used for comfort or to prevent women turning over in bed, as the pain of turning over woke them up.

The effect on their ability to perform mundane tasks, previously taken for granted, left them feeling isolated and lonely. Some felt that their incapacity had affected their relationships with everyone around them. Women who had young children were affected most profoundly, since they felt that they could not do anything for the children. As these children were too young to understand explanations given by either parent, this led to an increase in anxiety for the women.

The type of extreme situation in which one woman informed the researchers that she was contemplating suicide had not been anticipated prior to the study. Their response ensured that she received the support that she needed, but this does reinforce the importance of researchers being prepared and able to deal with such difficult issues when studying areas that can affect participants' mental health and wellbeing profoundly.

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### Conclusion

There can be no doubt that SPD can have a devastating effect on many of the women who are diagnosed with it, particularly those with severe SPD, to the point where even suicide may be contemplated. Healthcare professionals have a duty to take SPD seriously and to work closely together to provide support for women with the condition. Midwives require more training in managing women presenting with SPD, since they are the main carers of sufferers and are ideally placed to refer to other healthcare professionals.

For the researchers, it was a humbling experience to listen to the distressing stories told by so many apparently healthy, pregnant women. The need to raise awareness of SPD and to improve the information and support available for these women is of paramount importance.

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### Recommendations for practice and education

Recommendations that may be drawn from the findings of this study include:

- Raise awareness of the effects of SPD among all staff dealing with pregnant and newly-delivered women
- Institute routine questioning of pregnant women about the symptoms of SPD so that diagnosis can be made and management instituted as soon as possible
- Disseminate the findings of this study using a multi-disciplinary approach through publications and conference presentations
- Formulate guidelines for the management of SPD
- Include the social and psychological effects of SPD in training packages and education programmes to enable midwives to be supportive of women with this condition
- Conduct more research to ascertain the cause and improve the treatment and management of SPD.

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