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Recovery after childbirth: A qualitative study of postpartum women

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Implication statement

Research in the postpartum period has been largely quantitative and focused on obstetric dysfunction, major depression and impact of epidural analgesia. The purpose of this study was to describe women's perception of postpartum pain and identify specific impediments to better pain management.

Abstract

Introduction: During the postpartum period women do not usually have health issues reviewed until 6 weeks. The purpose of this qualitative study was to examine women's experiences in the postpartum period and identify specific impediments to better pain management.

Methods: 32 women delivering at Mount Sinai Hospital consented to participate in semi-structured postpartum home interviews conducted one month after delivery. Recruitment involved purposive sampling. Interviews were audiotaped and transcribed verbatim. The qualitative analysis of the interviews included primary coding and clustering these codes to identify common themes and subthemes.

Results: Out of 32 participating women, most were primiparous, delivered vaginally, over 30 years old and were higher socioeconomic status. For most women, physical recovery after delivery was hindered by at least one of the four major concerns including: breastfeeding pain and difficulties, delivery pain, reduced mobility and wound complications. An important finding of this study was the sense of abandonment by health care providers that some first-time mothers expressed. Only 50% of women received a follow up phone call from the community public health nurse. Suggestions for improving postpartum experience for future mothers were mainly focused around preparation, getting help and acknowledging that personal reaction to the events is variable and unpredictable.

Conclusion: The women in this study reported unanticipated and unwanted physical and emotional health outcomes following delivery. This information can be used in the design of a better postpartum management programs in the future.

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Introduction

Traditionally, the first check-up does not happen until 6 weeks postpartum. Systematic appreciation of maternal morbidity of this period is lacking [1-5]. The issue is further compounded by recent service changes allowing women to be discharged earlier following delivery.

Antenatal care has focused largely on delivery and baby care, with little information given on the postpartum physical and emotional morbidity for the mother. During a systematic evaluation of women post-vaginal delivery, we discovered many having significant pain during the first week, yet they failed to use physical or pharmacological measures to relieve it [6].

Caesarean delivery has been associated with significant postpartum pain. The results of a US national survey of postpartum women indicate that seventy nine percent of women following a caesarean delivery experienced pain at the incision in the first 2 months after birth, with thirty three percent describing it as a major problem, and eighteen percent reported persistence of the pain into the sixth month postpartum [7]. The purpose of this study was to describe women's experience following childbirth.

Methods

This was a qualitative study approved by the Mount Sinai Hospital's Research Ethics Board. Participants were identified from a sample of women delivering from May 23, 2011 to November 5, 2011. Recruitment involved purposive sampling to ensure representation of 8 categories (Table 1). A semi-structured in-person interview with each woman was conducted at 3-4 weeks postpartum. All interviews were audio-taped and transcribed verbatim. An interview topic guide acted as a prompt, however, participants were encouraged to share what was important to them. Field notes were recorded to capture additional conversation not collected on audio-tape. Interviews averaged approximately 40 minutes. Data saturation was reached after interviewing 32 participants.

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Table 1. Distribution of participants by study categories.

Study category	N (%)
Parity:	
Primiparous	22 (69%)
Multiparous	10 (31%)
Gestational age at delivery:	
Term	30 (94%)
Preterm	2 (6%)
Delivering physician:	
Obstetrician	30 (94%)
Family physician	2 (6%)
Delivery type:	
Vaginal	18 (56%)
Primary cesarean section	8 (25%)
Repeat cesarean section	6 (19%)
*Perineal trauma:**	
Mild (no tear or 1st degree)	4 (22%)
Moderate (2nd degree or higher)	12 (67%)
Episiotomy	2 (11%)
Socio-economic status:	
Green score <65	8 (25%)
Green score >65	24 (75%)
Maternal age:	
30 years and younger	13 (41%)
31 years and older	19 (59%)
*Type of anesthesia:^*	
General	2 (14%)
Neuraxial (epidural, spinal)	12 (86%)

*Includes only women who had vaginal delivery
^Includes only women who had caesarean delivery

Transcription and preliminary data analysis were undertaken simultaneously to check for emerging concepts. The authors highlighted potential key themes to be explored in the future interviews. Thematic analysis continued up to the completion of all interviews and new ideas were checked against the data. The qualitative analysis of the interviews included primary coding, clustering these codes to identify common themes and final consensus was reached among all authors.

Results

Total number of deliveries during the study period was 3135. 73 postpartum women were approached and 32 women interviewed. Characteristics of study participants are summarized in Table 1. Responses were grouped in the following themes (Table 2). A detailed discussion follows with representative participant quotes.

Pain characteristics

All study participants reported pain ranging from non-significant to severe incapacitating pain. All women who had caesarean section complained of incisional pain, whereas 89% of respondents recalled pain in perineal area following vaginal delivery. Other sources of pain were associated with breastfeeding, hemorrhoids, lower back pain, and “achy” legs. The intensity of pain ranged from 2 to 10 on 0-10 numeric pain scale with the most common intensity of 6. Majority of women (25) rated pain either as or less than expected. Among those with unanticipated pain, breastfeeding pain was the most commonly cited.

“*It was shocking to find out how much the breastfeeding hurts. That was the only time in my adult life I broke in tears with pain…”*

“Everyone talks about delivery pain, but no one talks about breastfeeding pain, it was unexpected and difficult”

Half the respondents were pain-free by the time of interview with the majority reporting substantial improvement in 2-3 weeks after delivery.

Pain management

All women used pharmacological or non-pharmacological measures to manage pain. A combination of acetaminophen and ibuprofen was the most common. Nine women also took oxycodone. Among non-pharmacological measures, sitz baths were the most popular, followed by a perineal bottle and cold pads.

Lack of time was the most commonly cited factor limiting pain relief efforts:

“I never had time to do sitz baths…He [baby] was on a really demanding feeding schedule, so with that little time in between I was trying to sleep…”

“…there is not much time to focus on pain. Looking after the baby is the priority.”

Among the reasons for avoiding oral analgesics, fear of dependency was the most common:

“I didn’t use oxycodone because pain was getting better. It is a strong medication and I heard people get dependent on it…”

Potential effect on a neonate was another common concern:

“I was not comfortable taking any pain medication, because of the breastfeeding and I thought, it might affect my milk production…”

“Oxycodone makes you drowsy, you cannot drive and it might get into breast milk…”

Among other reasons, women mentioned medications being “unnatural”, and the fact that “having a baby” is supposed to be painful.

“The confusing part is that the books say there should be no pain with breastfeeding. I demonstrated correct technique, but still felt a lot of pain. So, I realized that can never be pain-free.”

Impact of pain on life and activities

Despite the fact that all respondents have experienced some degree of pain, the majority of them reported little or no effect of pain on their daily activities

“I was functional for sure…it just slowed me down a bit…”

“I guess because your stomach is tender, you get out of the bed differently, but...I was doing that when I was pregnant anyway.”

The most common effect of pain was difficulty with walking and climbing stairs, which affected women’s ability to care for themselves and do certain home chores:

Table 2. Themes from interviews.

1. Presence of pain and its characteristics: a. Location. b. Course. c. Intensity and its degree versus expected.
2. Pain management: a. Medications. b. Non-pharmacological therapy. c. Social support system. 3. Limitations that affected pain relief efforts.
4. Impact of pain on life and activities: a. Mobility and daily activities. b. Mood, sleep and energy levels. c. Family relationships.
5. Utilization of healthcare resources: a. Public health nurse. b. Hospital discharge care. c. Other.
6. Suggestions to better prepare women to deal with postpartum issues.

"It was hard to get in and out of the car…Bumps on the road would hurt...I could not coordinate to do anything around the house, going upstairs was hard…"

"I felt like an old lady. It did interfere with breastfeeding. I always made sure to use a cushion, so baby was not pressing against the incision.…"

"On the day of discharge I realised that I don't have that hospital bed at home; they should teach us how to get out of bed".

There was no significant difference between women with vaginal delivery and caesarean delivery in the share of respondents reporting mobility problems due to pain ($p>0.05$). However, longer hospital stay after caesarean delivery may have resulted in reduction of pain intensity by the time of discharge.

Many women also reported emotional problems, irritability and mood swings:

"There was a lot of snapping, but I think it had a lot to do with the hormones, tiredness with pain on top."

"Your old selfish life is gone, you cannot sleep in or eat when you want to, so all that and pain on top, make you feel like going insane."

"The first two weeks I was very emotional. I have heard about baby blues, but was really surprised by the intensity of it. I felt anxious and insecure, tearful, and irrational, not about the baby. It was about my own life, and I was very overwhelmed."

In one case pain has contributed to tension in relationships:

"…I had really bad mood swings…because I was in so much pain... small things would bother me... So, pain definitely affected my mood."

Utilization of healthcare resources

Study participants were asked if they were contacted from assigned Public Health nurse (PHN). 56% of respondents answered "no".

Among those who interacted with PHN, there were conflicting opinions about utility of the services.

"First she [PHN] called to ask a few questions and gave her phone number, to call her if I had any questions. I did a couple of times and it was helpful."

"One [PHN] gave me a call, went through a checklist of questions and said: "If you have any questions call me, but I am on vacation for the next 2 weeks." I did not feel like I was a person to her."

Most women not followed up by PHN felt that previous experience or friends equipped them with enough confidence and a visit from PHN would not be necessary. However, some second-time mothers felt that they would have benefited from this service.

"Emotionally it would be nice to have someone say:"It is normal to hurt that much"…but I don't know what they could have done to help me further..."

"I think that follow up is important. It's good to feel like there is somebody there connected... I could have used the nursing help and I did end up paying somebody else to fill that gap, but there are people who cannot pay for that service...Although the doctor's office answer your questions, it is more formal environment compared to someone coming to your house...and even though it is my 3rd [baby] there are still some questions."

The respondents were asked if information, received from the hospital helped to manage postpartum pain better:

"I think they did a good job in the hospital by talking about what kind of pain medications to use and even starting you off, gives you an idea of a ritual."

However, not all women thought that the information in the printed materials was specific enough:

"The brochure was general, nothing specific...so I cannot say that equipped me with anything...It was about what to do for the baby, not about what to do for me..."

Breastfeeding consultation was the most commonly used healthcare services. Those services were mainly used by primiparous women. Overall, respondents found them very helpful. Some of the respondents hired private lactation consultants because they thought the latter provided better services, as well as for convenience of home visits:

"Even though we live close, going for the appointment is really difficult, I have to bring him [the baby] hungry, screaming, so a private lactation consultant is more flexible, she could stay for the whole feeding, and she seemed more knowledgeable"

Despite the fact that the majority of women (30) experienced health problems in postpartum period, less than half of them actively sought help from healthcare providers. Several respondents mentioned that they considered asking questions regarding their own health during baby check-ups, but did not do it because baby's health was a priority for both them and the doctors:

"Everything was around the baby…If someone asked me: "How is your pain?", I would have said: "I need some help managing it…"

Some women felt confused because they didn't have clear idea which provider was responsible for their health in postpartum period:

"Sometimes the question is who you call to ask simple things. Do you call your OB or family doctor? You don't know for the first 6 weeks, so that's a little unnerving..."

Most first-time mothers emphasized that they felt strong sense of abandonment from the health care providers during postpartum period in comparison to what they experienced prior to delivery:

"Someone is watching over you and making sure things are fine [during pregnancy]. And then you have a baby, and it is kind of "see you in 6 weeks". That's awfully long time…They say "if anything abnormal, call", but I did not have a baby before, so I don't know what's normal."

Suggestions to better prepare women to deal with postpartum issues

All study participants suggested that future mothers should be better prepared to deal with postpartum issues. Part of this preparation includes having information about available services.

"It was helpful knowing about postpartum issues in advance. Prenatal classes tell us what to expect. It would be helpful if OB reinforced this information…"

"Would be good if women knew about all the resources out there, like the lactation consultant, a walk-in breastfeeding clinic, and the public health nurse."

There was a difference in opinion about prenatal classes with some participants indicating that information given so far in advance is not perceived as real:

"People have talked to me about baby blues and the pain, but it is not real until after you had a baby. So, either have the nurse talking to you the week that you deliver, or closer to delivery day, specifically about pain management and emotional disturbance."

The majority (27) of respondents indicated the importance of getting help with home chores to allow more time for rest, potentially contributing to faster recovery:

"Get help! It means somebody coming to stay to prepare food and tidy up the home because you cannot do that."

"I really think that there should be an opportunity for people to recover in the hospital before they come home. Even if it is one solid night sleep."

Several (10) participants emphasized that mothers should not be afraid of taking analgesics, because pain control is important for recovery:

"Take as much as you need, because if you are not feeling well, then the rest of the process will not go well."

Finally, several participants (7) pointed out, that expecting mothers should account for the fact that personal reaction to the events varies and is hard to predict and prepare for:

"It is one of the things that you don't know till you are in it…"

"*I don't know if anything could prepare you for these first couple of days. It's just a combination of nipple, vaginal pain, sleep deprivation, confusion about how to care for the newborn and the emotions. Prenatal classes did not prepare me for that, nobody could prepare for that…*

Discussion

Our qualitative study offers insights from Canadian women during the postpartum period. Routine perinatal surveillance data do not completely capture women's perceptions regarding postpartum period. Yet, those are of great importance in understanding perinatal health and evaluating policies. The Canadian Maternity Experiences Survey [8] was designed to address this gap. However, like any survey, it collected quantifiable data on hospital length of stay, breastfeeding rates. Concepts like satisfaction with care or quality of postpartum information was assessed by responses to pre-defined questions. In contrast to the numeric data, qualitative research involves systematic observation and analysis of human behaviour and may be more suited for explanation of certain social phenomena [9].

Qualitative methodology has been used in studies about the postpartum period, however those studies have looked at isolated issues such as pelvic problems [10], postpartum depression [11,12], specific populations [13,14] or health behaviors [15,16].

Women in this study reported a range of physical and emotional health outcomes following delivery, including breastfeeding pain (25), reduced mobility (12) and wound complications (2).

In the first few weeks, women largely concentrated on managing the impact of childbirth on their daily activities. "Returning to normal" is significant for women and successfully achieving daily activities is part of this process. Some women seemed unprepared for the reality of this experience. Recognizing that there is a "new normal" was challenging for some. This huge change in woman's life has to be recognized to successfully move into motherhood.

Following caesarean delivery, women were given routine post-operative instructions similar to patients after any major abdominal surgery. Similar to findings of Kealy [14], this advice was ignored by some women, who, once at home, had little choice but to assume caring for the family. Perhaps more emphasise on the importance of following instructions before discharge could help to secure extra help from the other family members, so the woman can be granted this time for herself.

It was reassuring that many women realized the importance of looking after themselves in order to provide care for the newborn. Not surprisingly, all multiparous women reported pain and disability being less than expected, compared to previous deliveries. This finding might be explained by introduction of multimodal analgesia regimens and by having "previous experience" to compare with.

A surprising subtheme was the lack of utility in providing information about the postpartum period in the prenatal period. The findings from this study suggest it is important to find different ways of communicating the information. Providing information early in the postnatal period, in addition to what is provided during pregnancy might be another option to reinforce the teaching. Expectant mothers are concerned about the delivery and maybe unable to focus on issues that emerge postpartum. While patients can obtain information on postpartum analgesia from a variety of sources, the quality of the information will likely vary with the source. This variation in the accuracy of information underscores the need for communication between patients and providers to ensure that patients are making informed decisions.

Some women indicated they were confused about who to call in the postpartum period. This situation might be even more distressing to women without a family doctor. In the setting of multiple providers it is important to clarify who to call if there is a problem.

Although medical professionals are trained in addressing physical and psychological problems, this study suggests the needs of the mother may get missed in a rushed "baby check". Care in the postnatal period should encapsulate a holistic approach and be inclusive of both the mother and the newborn. The physical symptoms of pain should not be tackled in isolation from the psychosocial impact. A breastfeeding clinic is an example of this approach with a less "formal" setting that women could visit more frequently and receive more support than in a busy doctor's office.

Although a recent systematic review of the literature on postpartum care did not find evidence to endorse universal provision of postpartum support to improve parenting, maternal mental, physical health or quality of life, there is some evidence that high-risk populations may benefit from postpartum support and qualitative literature may add significant insights into the utility of this intervention [17].The limitation of the study is that it included only English speaking women, interviewed on one occasion only and all women had a partner. The study took place in a tertiary care center, with fairly consistent discharge protocols and resources available, therefore the responses may not be reflective of women delivering in smaller community centers across the country. Additionally, study participants were of mixed parity, so the previous experience may have biased the subsequent.

Conclusion

The extent of postnatal morbidity has increasingly been recognized in recent years. Some women may be poorly prepared for the impact of issues in postpartum period, especially related to successfully completing daily living activities.

This study could be used in the design of a future, multidisciplinary clinical trial of a postpartum management program. Our findings may be useful to clinicians when counseling women about their analgesic options, so that providers can specifically address areas that are of concern to patients.

Patient-centered counseling may improve the quality of care, as fears based on inaccurate information may be alleviated. Future work should evaluate the quality of patient provider communication during analgesic counseling and identify targets for quality improvement.

Disclosure

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