LOOKS AND KNOWLEDGE: EXPERIENCES OF MOTHERS AND NURSING STAFF REGARDING POST-CAESAREAN SECTION PAIN

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ABSTRACT: The aim of this exploratory-descriptive study was to identify the perceptions, knowledge and actions of postpartum women and nursing staff regarding pain after cesarean section. Data were collected through semi-structured interviews, conducted in May 2011 with 40 postpartum women who underwent a cesarean section, at the Rooming-In unit of a maternity at a teaching hospital in Florianópolis-SC, Brazil, and also with 22 nursing team members who attended the postpartum women. Data were analyzed in accordance with the Collective Subject Discourse proposal. The results show that pain after cesarean delivery is a reality all mothers who undergo this delivery method experience, although the nursing professionals are not anonymous about it, indicating the need to invest in professional qualification on pain management, including training and recycling.

DESCRIPTORS: Cesarean section. Pain. Nursing staff.

OLHARES E SABERES: VIVÊNCIAS DE PUÉRPERAS E EQUIPE DE ENFERMAGEM FRENTE À DOR PÓS-CESARIANA

RESUMO: Trata-se de uma pesquisa exploratório-descritiva que teve por objetivo identificar a percepção, o conhecimento e ações da puérpera e da equipe de enfermagem frente à dor pós-cesariana. Os dados foram coletados através de entrevistas semiestruturadas realizadas no mês de maio de 2011 com 40 puérperas submetidas à cesariana, no Alojamento Conjunto da Maternidade de um hospital-escola de Florianópolis-SC, Brasil, e também com 22 membros da equipe de enfermagem que prestou assistência às puérperas. A análise dos dados foi realizada de acordo com a proposta do Discurso do Sujeito Coletivo. Os resultados evidenciam que a dor pós-cesariana é uma realidade vivenciada pela totalidade das puérperas a ela submetidas, apesar de não ser unanimidade entre os profissionais de enfermagem e apontam para a necessidade de investir-se na qualificação profissional no âmbito do manejo da dor, tanto em nível de formação, quanto em nível de atualização.

DESCRITORES: Cesárea. Dor. Equipe de enfermagem.

MIRADAS Y CONOCIMIENTO: EXPERIENCIAS DE LAS MADRES Y EL PERSONAL DE ENERMERÍA COM RESPECTO A DOLOR POST CESÁREA

RESUMEN: Se trata de un estudio exploratorio-descriptivo. Tuvo como objetivo identificar las percepciones, conocimientos y acciones del post-parto y el personal de enfermería en relación con el dolor después de una cesárea. Los datos fueron recolectados a través de entrevistas semi-estructuradas realizadas en el mes de mayo de 2011, con 40 mujeres sometidas a cesárea post-parto, en el alojamiento conjunto de una maternidad en un hospital- escuela de Florianópolis-SC, Brasil y también con 22 miembros del personal de enfermería que proporcionaban asistencia a las madres. El análisis de los datos se realizó de acuerdo con la propuesta del Discurso del Sujeto Colectivo. Los resultados muestran que el dolor después de una cesárea es una realidad que enfrentan todas las madres que se refiere a ella, aunque no la unanimidad entre las enfermeras, e indican la necesidad de invertir en la capacitación en el manejo del dolor, tanto en el nivel de formación y actualización.

DESCRIPTORES: Cesárea. Dolor. Personal de enfermería.

INTRODUCTION

Caesarean section, also called C-section, is a surgical procedure for deliveries and involves a (transverse or vertical) skin incision, above the pubic hair line, successively opening the subcutaneous tissue, the aponeurosis of the rectus abdominis muscles, separating the muscles at the midline, opening the parietal peritoneum, the visceral peritoneum and then the uterine wall, from where the fetus is extracted, followed by the removal of the placenta and review of the uterine cavity, and finally, the suturing of the incised levels.[1]

This procedure was developed to prevent or treat a threat against the mother's life and/or fetal complications. Its indications include: delayed progression, acute fetal suffering, fetal-pelvic disproportion and high-risk pregnancies, among others.[2]

The C-section always provokes a trauma in the woman's organism, greater than the trauma a normal birth causes. The abdomen is cut, the muscles are put out of place and the abdominal cavity is invaded. All of this provokes an accumulation of gases, pain, reduced intestinal movements and a slower postpartum recovery.

The World Health Organization (WHO)[3] recommends a C-section rate of about 15% as acceptable. The global report by the United Nations Children's Fund (UNICEF) showed that the rate in Brazil stands out, corresponding to 44% between 2005 and 2009, the highest rate in the world. At some private health services, more than 90% of all births are C-sections. In the public network, on the other hand, these rates drop to between 30 and 40%. A study ordered by the Brazilian Ministry of Health shows that, in 2006, C-sections represented 45% of deliveries in the country.[5] Data for 2007 show a rise to 47%, which means than almost half of the three million births in the country that year were through C-section. In an analysis developed between 2001 and 2008, C-section rates increased from 38.00% to 48.8%, reaching 52.00% in 2010.[6] In Santa Catarina, in the last two years (2010 and 2011), the rate amounted to 42%, which tends to rise even further depending on the growth rhythm in recent years. Data by the State Secretary of Health appoint that, in 2005, C-sections represented 20.5% of the almost 50 thousand births registered in Santa Catarina. This rate had increased to 39.7% in 2008 and in 2010 and 2011, based on data from January to October, general counts surpassed 42%. Nevertheless, the rate in Santa Catarina remains below the national average.[6] This progressive increase in the number of C-sections may reflect the still common fear of normal birth, due to its association with pain. It is highlighted that, at the start of the 1980's, research had already concluded that, when the woman chooses to give birth through C-section, 99% attributes this choice to the fear of pain.[7]

This shows that many women have been submitted to C-section in the Brazilian reality, indicating that surgical birth turned into the "normal" method to bring a child into the world, inverting natural life values. For many women, the choice of this surgery (elective C-section) entails the desire to flee from the pain of giving birth, considering the C-section as an "anti-painful" way of having children, showing disinformation about post-Caesarean pain and its interference in the establishment of care for the infant. Postoperative pain is inherent in the C-section though, as this is a medium to large surgery that demands medical and nursing care, mainly for postoperative pain relief.

We cannot forget that a woman submitted to a C-section is not only a patient who demands postoperative care, but also a puerperal woman, who needs to start taking care of the newborn and be able to breastfeed. The pain present after the C-section makes the recovery more difficult and delays the mother's contact with the infant, and also acts as an obstacle to good breastfeeding positioning, self-care, care for the infant and, finally, for daily activities like: sitting and getting up, walking, intimate hygiene, among others.[8]

Maternal breastfeeding is acknowledged because of its importance, not only for the infant's health, but also for the mother's health, and especially for the relationship between both. Through this interaction, the infant develops more security and the mother gains self-confidence about her ability to take care of her baby. Some factors can interference in perfect breastfeeding performance, including postpartum pain. The medical and nursing team accompany post-Caesarean section women's hospitalization period, evaluating their general status and homeostatic conditions and delivering comforting care, including the guarantee of pain relief. The success of acute pain treatment depends on an accurate evaluation of this experience.[9]

The particular condition of postpartum women after C-section in comparison should

be distinguished from patients submitted to other surgical procedures, due to their greater need to move around to take care of the infant and herself. Hence, they are subject to greater incision pain.[10]

In our daily professional practice, we have observed that post-Caesarean pain complaint have not always received proper attention, as each caregiver's sensitivity may vary according to the importance and value (s)he attributes to the other person's pain.

The idea that there are options, even within the established standards, to enhance individual pain relief does not seem to be well disseminated among post-Caesarean women. Lack of knowledge about medicines and client rights has caused insecurity in the health team, especially among nursing team members, who have often neglected pain and considered it "normal", as evidenced in some discourse observed in care and teaching practice. In that sense, we have observed different attitudes and conducts, which reveal that post-Caesarean pain is trivialized, including justifications that barge into the premises of care, demonstrating a lack of willingness to improve the analgesics or even to establish conditions that comfort the post-Caesarean woman.

In view of post-Caesarean pain, some nursing team professionals' conducts tend to range from indifference to homogeneous pain treatment, either due to missing tools or willingness to assess each individual's pain distinctively, prescribing and/or administering the same analgesia to all women. On the other hand, some professionals continue to repeat and transmit the belief to the client and her family that that is how it is, that Caesarean section hurts, without offering any pain relief option beyond the standards though. This fact seems to have become part of professionals' daily reality and imaginary, making them adopt outdated pain care procedures. This scenario indicates an apparent lack of professional training for individual care in pain relief, making care dehumanizing due to the bad quality and problem-solving ability of care, going against the principles of the National Hospital Care Humanization Program (PNHAH), which the Brazilian Ministry of Health created in 2000.[11]

Departing from the premise that the human and subjective dimension of pain, underlying any health intervention, from the simplest to the most complex ones, greatly influences the efficacy of hospital care delivery, the PNHAH considers humanization as the valuation of the different subjects involved in the health production process, who are: users, workers and managers. According to this policy, humanizing means offering high-quality care, articulating technological values with welcoming and improvements in care environments and professionals' work conditions.[11]

As mentioned, in our professional reality, we have verified that post-Caesarean pain complaints have not always received proper attention. Therefore, also considering that nursing plays an important role to put in practice humanization in health services and that humanized care includes individualized care to women, focusing on her specific complaints and care demands, we have formulated the following research question: what are the perceptions, knowledge and actions of postpartum women and the nursing staff who delivers care to them in the hospital environment regarding pain after cesarean section? To answer this question, this research was developed to the identify perceptions, knowledge and actions of postpartum women and nursing staff regarding post-Caesarean pain.

METHOD

A qualitative exploratory and descriptive study was undertaken in May 2011 at the Rooming-In unit of the Maternity at the University Hospital (UH) located in Florianópolis-SC, Brasil. The UH is a medium-sized public teaching hospital that delivers medium to high-complexity care and exclusively attends through the Unified Health System. The Rooming-In Unit offers 22 obstetric care beds and attends to approximately 1600 births per year, with an average 70 Caesarean deliveries per month. The UH has been accredited by the Brazilian Ministry of Health and the United Nations Children's Fund (UNICEF) as a Baby-Friendly Hospital since October 1997, obtaining international recognition and turning into a municipal, regional and state reference in the area.

The target public in the study consisted of 40 women, out of 73 women subject to Caesarean delivery during the data collection period, as well as 22 nursing team members working at the Rooming-In Unit and who attended these women. The number of postpartum women in the sample were the women who accepted to participate in the study during the data collection

period, as the Collective Subject Discourse (CSD) does not use the saturation technique, in view of the intent to get to know all representations on a given research theme. Saturation presupposes that, at a given time, representations are repeated. This premise entails the risk of collecting only the most frequently shared representations and not all representations, which is the intention of the CSD.[12]

For data collection, semistructured interviews were used, with the help of a script the authors created, which was applied during the first 24 hours of hospitalization at the Rooming-In Unit. The script differed for the postpartum woman and for the nursing team. The interview script comprised identification data, including sociographic and obstetric data, the latter of which addressed possible problems occurred in the trans-operative and post-operative phase. Next, the occurrence of post-Caesarean pain was investigated, how the postpartum woman and nursing team perceived it, how the postpartum woman and team attended to the pain complaint and the problem-solving ability of the established treatment. The nursing team script comprised identification data, including sociographic and education/training data. Next, the team's perception of the post-Caesarean pain was investigated, its concept, besides evaluating the postpartum woman's pain experience, her pain management and educational preparation to attend to the pain complaint.

Data collection only started after the participants had received explanations about the research and formalized their acceptance to participate in writing, through the signing of the Informed Consent Form (ICF).

After data collection, thematic discourse analysis was undertaken, in line with the CSD method, which is aimed at organizing and processing the qualitative data, extracting the Central Ideas (CIs) and their corresponding Key Expressions (KEs). Based on the KEs with the same CI, one or different Synthesis-Discourses (SDs) are elaborated in the first person singular.[12]

The research project received approval from the Ethics Committee for Research Involving Human Beings at Universidade Federal de Santa Catarina, Protocol 359/11. All procedures were in compliance with National Health Council Resolution 196/96, which standardizes and regulates research involving human beings.

RESULTS AND DISCUSSION

Characteristics of the puerperal women

The 40 study participants were in the age range between 14 and 40 years, the majority (18) had finished secondary education, two had finished higher education, three were in college, four had not finished secondary education, six had finished primary education and seven had not finished primary education. Regarding these women's marital status, the majority (23) was living with a fixed partner, 13 were married, three were single and one gave no information. Four of these women gained one minimum wage (MW) per month, 12 two MWs, 11 three MWs, four gained four MWs, five more than five MWs and three had no income. Thirty-seven women came with a companion during the hospitalization. With regard to parity, 15 had their first child, 15 the second, five the third and five gave birth to multiple children. All women were interviewed on the second postpartum day. The reasons for the C-section varied between: absence of dilation (16), concerning fetal situation (five), third and fifth C-section (six), pregnancy hypertension (five), pelvic fetuses (three), problems with the fetuses, such as hydroencephalitis and cardiopathy (two), low amniotic fluid (um), twins (one) and complications due to HIV (one).

Characteristics of nursing professionals

Research participants were 22 nursing team members, 20 women and two men. Five of them are nurses, two of whom nurse-midwifes, ten are nursing technicians and seven auxiliary nurses. The time of experience in the area ranged between six and 28 years.

Postpartum women and nursing team's experience with post-Caesarean pain

The central ideas that emerged from the interviews with the postpartum women and the nursing team refer to post-Caesarean pain aspects according to the postpartum women and the nursing team, the nursing team's range of conducts for pain relief according to the postpartum women and the nursing team and the need to equip the nursing team for pain management and relief care.

CI1 – The post-operative phase after C-section hurts

The following key expressions emerged from the postpartum women's discourse: *when the effect of the anesthesia passed I felt a lot of pain. When I got up for the first time, I almost fainted because of the pain, I felt bad. It hurts, but I'm used to it, it's the fourth C-section, it's normal to feel pain. It hurts a lot to get out of bed and get the baby. The cut hurts.*

Postoperative pain is inherent in the Caesarean section because, as mentioned, this is a medium to large-sized surgery that involves abdominal opening. The postoperative incision pain at rest and while moving is one of the manifestations of cell lesion and inflammation processes resulting from the surgery, which is often difficult to control through conventional analgesia with opioids.[13]

Basically, the tissue injury and the subsequent inflammatory process cause the postoperative pain. In combination with this initial cause, there is primary postoperative hyperalgesia, which refers to the extension of the local painful process to regions adjacent to the injury, due to the intensive release of algogenic mediators, responsible for potentiating the original painful process. This process causes the reduction of the pain threshold and the increased sensitivity of adjacent nerve endings, causing hyperalgesia to stimuli that did not use to produce pain, like tactile stimuli for example.[14] This whole context implies a slower postpartum recovery, demanding care from the medical and nursing team, mainly with regard to postpartum pain relief.

The pain threshold varies from person to person, according to his/her culture, independently of anatomical and physiological bases. In combination with this pain threshold variability factor and tolerance, pain is difficult to assess, as it is a personal and subjective event with multidimensional characteristics and molded by a range of influences, involving the psychological, emotional, cognitive, social and cultural dimensions.[15]

Post-Caesarean pain entails another aggravating factor: the risk of interfering in successful breastfeeding, a crucial factor for a calm postpartum period and a healthy infant. Post-Caesarean pain interferes negatively in the mother's ability to breastfeed. In a research that involved 60 women, it was concluded that, the higher the pain degree the woman experiences in the postpartum, the lower the breastfeeding performance. This fact was observed in elective C-sections as well as emergency situations. The risk of postoperative pain, however, was higher when the emergency procedure was applied. The worse the pain experience, the worse the care for the infant will be. Procedures that permit greater pain relief after the C-section, such as effective and safe analgesic drugs, are fundamental measures for the mother's breastfeeding and care of the infant.[16] Post-Caesarean pain assessment and characterization resources are needed, with a view to humanized care delivery, as well as adequate pain treatment resources.[8]

In CSD1, pain is present as discomfort in the discourse of all postpartum women who were submitted to C-section, in line with the literature on the difference and range of referred pain intensity.

The report that pain is normal indicates that women ignore their rights as health system users and their rights to health care free of damage and discomfort. According to different women, what is "normal" is to feel pain in any surgery, which is the case for some puerperal women in this study, indicating the need for actions to inform the population about the right to analgesia in accordance with individual needs and the right not to feel pain in the postoperative phase.

CI2 – The post-operative phase after C-section does not always hurt

The nursing team professionals' discourse revealed the following key expressions:

[...] *it is not always painful. There are various pain levels. More for some patients, less for others, or nothing. Pain happens depending on each situation and each patient's pain threshold. Some come with residual anesthesia and a medication schedule, leading to the absence of pain; the women who are vomiting or coughing feel more pain. You can't prove pain, I trust in the pain the patient reports.*

Each caregiver's sensitivity can vary according to the importance and value (s)he attributes to the other person's pain, as the patient's self-report is the safest indicator of its intensity. Thus, patients subject to the same procedure can experience different pain levels, making it crucial to believe in and readily respond to a patient who mentions pain.[17]

Pain complaints should be evaluated across the entire hospitalization, including the characteristics of the pain site, intensity, frequency,

duration and quality of the symptom, and should be registered in each institution's appropriate instruments.[18]

The fact that post-Caesarean women's pain is not valued seems to relate to some professionals' difficulty to assess each individual's pain distinctly, offering few and limited options for relief beyond the standardized options. This fact seems to have become part of some professionals' daily practice and imaginary, who end up offering treatment that is hardly able to solve each individual's pain problem.

CI3 – The nursing team adopts a range of conducts in pain relief

The following key expressions were extracted from the postpartum women's discourse:

[...] *they do not offer options to improve the pain. I think they are used to seeing so many people in pain that they already find it normal. They haven't done anything so far. I think they forget. I think they did not consider the intensity of my pain. What can they do? They explained that it does hurt a little. They helped me to get up and said it is normal to feel this pain, so we settle for that. They offered medication for the pain to go away. They talked to the doctors, but it took a long time, and we have to wait, right? They told me to walk to eliminate the gases: as if that were easy! I'm the one who knows how much it hurts.*

Apparently, it seems that the idea that there are options, even within established standards, that enhance individual pain relief, still receives little value for women after Caesarean delivery.

The use of alternative therapies or non-pharmacological methods for pain relief in the post-operative phase after Caesarean delivery has hardly been observed. "[...] the main alternative therapies for pain relief are relaxation techniques, cutaneous stimulation, aromatherapy, guided imagination, vibration therapy and music, therapies that are put in practice with other nursing conducts, like enhancing the patient's comfort for example, avoiding the denial of pain, valuing and sharing the pain, avoiding patient manipulation, explaining the reason for the pain, offering psychological support and orientation on the pain relief measures taken. These complementary measures are mainly based on the promotion of relaxation, distraction and, consequently, on allowing the patient to feel more comfortable, furthering pain relief. Although the use of complementary therapies is incipient in nursing, a vast activity area is observed, as nurses constantly have contact with the patient and play an important role in the implementation of these therapies, with a view to pain relief and, consequently, a better quality of life for the patient".[19:1] It is important to clearly recall that, when using non-pharmacological pain relief methods, these methods demand a greater sense of control over their body and emotions from these women, factors that are not always present.[20]

Another possibility is appointed in a study that demonstrated the effectiveness of using Transcutaneous Electrical Nerve Stimulation (TENS) for pain relief. According to that study, transcutaneous nerve stimulation includes the transmission of electrical current through the skin, which will act on the peripheral mechanoreceptors and, then, be conducted by A-Beta fiber to a set of interneurons, which in turn act on the inhibition of the retransmission of the painful stimuli conducted by A-Delta and C fibers at the medulla level. Thus, the analgesic effects are related to a "closing the entry" mechanism in the spinal cord medulla and may also be associated with the release of endogenous opioids, as strong electrical stimulation is used, which will induce the release of these substances at the brain and medulla level.[21]

The postpartum women's discourse revealed that some professionals' attitudes and conducts are in line with a lack of knowledge on alternative and non-pharmacological pain relief methods, or which a lack of valuation of the post-operative phase after C-section. The justifications the postpartum women receive often go against the premises of care, revealing standardized and non-individualized care to each client's needs.

The range of conducts professionals at the same hospitalization unit, i.e. in the same team, adopt with regard to postpartum women's pain seems to indicate lack of knowledge and lack of equipment to treat the patient's referred pain individually, and not only through medication.

The medical and nursing team is responsible for monitoring post-Caesarean women's entire hospitalization period, assess their general status and homeostatic conditions and deliver comforting care, so as to guarantee the relief of their pain, which is these women's right and these professionals' duty.

Consequently, we find that patients who received kindness and attention from the nurse and

nursing team and perceive that they can count on the team are less anxious and, consequently, can actually feel less pain.[22]

Within the same central idea of the nursing professionals' discourse, the following key expressions emerged:

[...] *I talk to the patient and tell her that the C-section is always quite painful and that I already gave her what I had* [medication]. *I advise the patient to move around early and to walk in order to eliminate the gases, I give psychological support by listening to her. I ask her if her bladder is not full, if she does not want to urinate. When necessary, I apply ice on the incision under the nurse's orientation. I explain the reason for postpartum colic. I ask the companion to massage the back. I check the dressing, which is sometimes compressing a lot. I teach the patient to move around, using other muscles than just the abdominal ones. I ask the nurse to call the doctor for other measures if the pain has not been relieved. I argue with the doctor that the analgesia should be improved.*

A range of professional conducts is observed here, sometimes revealing deficient pain assessment abilities with a view to delivering care in accordance with each postpartum woman's needs.

It seems obvious that pain relief should be one of the care team's fundamental actions for women submitted to Caesarean delivery. While, according to some professionals, this care demands individual attention and willingness to engage in interventions, others trivialize the pain, indicating that they are more concerned with delivering the care than with a better practice.

IC4 – *Nursing team professional need to be equipped for care delivery in pain management and relief*

I was not prepared in my education for pain care, I studied on my own and participated in a couple of seminars on the theme. According to my own experience as a patient, the answers I heard from the nursing team revealed their lack of preparation to deal with pain. Professionals need recycling on post-operative pain treatment after C-section. I suggest informative lectures on non-pharmacological pain relief methods and training programs on the assessment of pain levels.

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO), a North American hospital evaluation organization, represented in Brazil by the Brazilian Accreditation Consortium, certify institutions that submit to the standards it defines in the international context, including pain relief on the list of items assessed with a view to hospital accreditation. This demonstrates the acknowledgement of patients' right to the evaluation, registration and control of their pain complaint.[18-23]

Attention to pain complaints and other vital signs is fundamental with a view to appropriate care delivery to each patient's suffering. Evaluation data underlie the etiological diagnosis of pain in order to prescribe analgesic therapy and evaluate the efficacy achieved.[24]

All things considered, it seems that the right not to feel pain and the right to analgesia or antalgic support has not been effectively addressed in professional education. Despite knowing that patients are entitled not to feel pain, according to many, the efficacy of this knowledge brings about little effect, as lack of knowledge leads to ineffective actions. This lack of preparation and awareness reveals a gap in professional education as well as continuing education in health services. Nursing professionals in this study demonstrated that they acknowledge this shortage in their education, making them express the need for recycling and deeper study on this theme.

FINAL CONSIDERATIONS

The present study results reveal that post-Caesarean pain is a reality all postpartum women submitted to this procedure experience, although with different thresholds, and that some women consider this pain "normal", making them conform, despite the discomfort caused.

On the other hand, nursing professionals are not unanimous about post-Caesarean pain, bringing about a range of pain relief conducts, which the women they take care of perceive.

In this context, almost all professionals who were interviewed declare that they acknowledge the shortages in their professional education background with a view to pain management and relief, arousing the need for education/recycling on this theme.

Considering that, as observed, the worse the pain experience, the worse care for the infant will be, and in the belief that the humanized care recommended in the PNHAH needs to include individual care to health users, in view of their specific complaints, we affirm that the post-Caesarean pain relief scenario found in this study strongly

indicates a fundamental need to invest in the nursing and health team professionals' qualification in pain management, involving both education and recycling. Therefore, the following recommendations are presented: a) for teaching institutions: to acknowledge these shortages in professional education and adjust their curricula to equip students for the recognition and effective treatment of pain complaints; b) for health institutions: to permit and stimulate their professionals to participate in education and recycling programs on pain relief, allowing them to gain knowledge on care technologies with a view to guarantees of risk-free care that offers security to patients, professionals and the institution, improving the quality of the care process in a humanized way.

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