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Recovery despite everyday pain: Women's experiences of living with whiplash-associated disorder

Päivi Juuso¹ | Lisa Skär² | Siv Söderberg³

¹Division of Nursing, Department of Health Science, Luleå University of Technology, Luleå, Sweden

²Department of Health, Blekinge Institute of Technology, Karlskrona, Sweden

³Department of Nursing Sciences, Mid Sweden University, Östersund, Sweden

Correspondence

Päivi Juuso, Division of Nursing, Department of Health Science, Luleå University of Technology, Luleå, SE-97187, Sweden.
Email: paivi.juuso@ltu.se

Abstract

Introduction: Living with whiplash-associated disorders (WAD) means living every day under the influence of pain and limitations. As the incidence of WAD and the related intensity of pain are somewhat higher among women than men, the aim of the present study was to describe women's experiences of living with WAD.

Methods: A purposive sample of seven women participated in individual in-depth qualitative interviews, the transcripts of which were subjected to qualitative content analysis.

Results: The results of the analysis suggested six themes of women's experiences with WAD: living with unpredictable pain; trying to manage the pain; living with limitations; being unable to work as before; needing support and understanding; and learning to live with limitations. The findings showed that unpredictable pain limited women's strength to engage in activities of daily life and be as active as before. Support and understanding were important for their ability to manage changes in their daily lives.

Conclusions: Pain considerably affects the daily lives of women with WAD, particularly by limiting their ability to perform activities and to enjoy their professional and social lives. As women with WAD need support with managing their daily lives, nurses and other healthcare personnel should adopt a person-centred approach, in order to support such women according to their individual needs and circumstances.

KEYWORDS

nursing, qualitative research, whiplash-associated disorder, women's health

1 | INTRODUCTION

In the present study, we focused on describing women's experiences of pain related to whiplash injuries, which are most common after motor vehicle accidents (Carroll et al., 2008). Even though the incidence of whiplash injuries related to road traffic accidents has been stable in Sweden over the last decade (Styrke, Stålnacke, Bylund, Sojka, & Björnstig, 2012), approximately 50% of the injured have suffered from the long-term consequences of their injuries, including whiplash-associated disorders (WAD) (Kullgren, Stigson, & Krafft, 2013; Socialstyrelsen, 2017). Rates similar to those of Sweden have been observed in international comparisons (Merrick & Stålnacke,

2010), and Vos, Abajobir, Abbafati, and Murray (2017) recently showed that, among women with musculoskeletal disorders such as neck pain, the number of years lived with such disabilities has increased since 1990. By definition, whiplash injury is the result of an acceleration and deceleration of energy transferred to the neck, which can prompt various clinical manifestations, collectively known as WAD (Spitzer et al., 1995). Trauma related to motor vehicle accidents occurs predominantly among men, who likewise suffer from whiplash injury more than women. The clinical manifestation of WAD, however, is more common among women, who also report pain of greater intensity compared with men (Koren, Peled, Trogan, & Norman, 2014).

The classification of WAD based on the Quebec Task Force Classification (Spitzer et al., 1995) or the modified classification based on the work of Sterling (2004) refers to the type and severity of clinical signs and symptoms observed shortly after whiplash injury. As no neuropsychological tests can be used to diagnose WAD (Rodríguez, Barr, & Burns, 2004), the diagnosis is based on the clinical presentation and medical history. The most commonly reported symptom of WAD is neck pain, although other common symptoms include neck stiffness, headache, dizziness and problems with concentration (Styrke, Sojka, Björnstig, & Stålnacke, 2014; Treleaven, 2011). Decrease in life satisfaction is common among people with WAD (Styrke et al., 2012), and poor self-rated health is a risk factor for non-recovery. Multimodal care, including education, exercise and manual therapy, has been shown to improve ways of coping with the symptoms of WAD (Sutton et al., 2016). However, Koren et al. (2014) argued that women should be treated more actively and given follow-up examinations more regularly than they currently are, in order to reduce the risk of experiencing the long-term consequences of WAD.

Living with chronic WAD means living with a pain syndrome that causes physical disability and, in turn, challenges with resuming normalcy, autonomy and spontaneity (Söderlund, Nordgren, Sterling, & Stålnacke, 2018). Bostick, Brown, Carroll, and Gross (2012) have shown that the stigmatization of people with WAD hinders their preparedness to communicate their experiences with pain to others, which consequently affects how they cope with the pain. In response, Ritchie, Ehrlich, and Sterling (2017) stressed to healthcare professionals the importance of capturing how people with WAD understand their pain and other symptoms, so that appropriate means to support their recovery can be promoted. Indeed, understanding from others is a prerequisite for accepting one's condition and acknowledging experiences with pain (Biguet, Nilsson Wikmar, Bullington, Flink, & Löfgren, 2016), both of which are important in the rehabilitation process. Sterling, Maujean, and Sterling (2018) added that patients' relationships with healthcare professionals are important for their morale and education as patients, and Skuladottir and Halldorsdottir (2011) encouraged healthcare professionals to support patients with finding effective ways to manage their pain.

Although the literature on WAD is extensive, research from the perspective of people living with WAD, especially that of women, remains scarce. As the disorders represent a complex pain syndrome that can differ from individual to individual, increased knowledge about women's daily experiences with WAD while recovering from their injuries can guide methods of managing pain and other WAD-related symptoms (Söderlund et al., 2018). Therefore, in our investigation, we aimed to describe women's experiences of living with WAD from their perspective, which can inform care designed to meet their individual needs.

2 | METHODS

We adopted an inductive approach for our qualitative study, the purpose of which was to describe women's experiences of WAD. Data

were collected by way of in-depth open-ended qualitative interviews and processed by using a qualitative content analysis according to Catanzaro (1988) which is suitable for narratives when the aim is to get condensed and comprehensive descriptions of the phenomenon under study.

2.1 | Participants and procedure

Seven women recruited from a rehabilitation centre in northern Sweden who met the sole inclusion criterion of having been diagnosed with WAD participated in the study. They were recruited by means of a purposive sampling in order to get participants with experience of the phenomenon under study and willingness to narrate their experiences (Polit & Beck, 2016). At the time of the interviews, the women were 35–51 years old (median = 44 years), were in a relationship, had children and were not working. All had been injured in car accidents, and at the time of the interviews 2.5–17.0 years (median = 8.5 years) had passed since their accidents. They had been diagnosed by their general practitioner or rheumatologist. To facilitate recruitment, we contacted the head of the rehabilitation centre to ask whether he could give information about the study to potential participants and enquire whether they were interested in participating. The seven women who consented to participate each received a letter containing information about the study. The first author later contacted the women by telephone, and scheduled appointments for their interviews.

2.2 | Data collection

The first author (P.J.) conducted and audio-recorded individual in-depth open-ended qualitative interviews with the participants. The data collection method was chosen based on the aim of the study and our interest of receiving comprehensive descriptions of the phenomenon under study (Sandelowski, 1991). Jointly, the authors (P.J., L.S., S.S.) developed the interview guide, after which the first author (P.J.) conducted the data collection. During interviews, the participants were asked to narrate their experiences of living with WAD and to describe how WAD had affected their daily lives. Clarifying questions were used when needed (e.g., "How did you feel?" "What did you think then?" and "Can you give an example?") (Table 1). Each interview lasted 60–90 min and was conducted in a setting chosen by the participant: at her home ($n = 3$), in a quiet room near her home ($n = 1$) or over the telephone ($n = 3$). The first author later transcribed all interviews verbatim.

2.3 | Data analysis

We analysed the interview transcripts by performing a qualitative content analysis, which generally involves identifying the primary patterns in a data set—that is, the content (Catanzaro, 1988). After

TABLE 1 Interview guide*Opening question*

- Can you please tell me about your experiences of living with WAD

Follow-up question

- How does WAD affect your daily life

Clarifying questions

- Can you tell me more?
- Can you give an example?
- How did you feel?
- What did you think then?

WAD: whiplash-associated disorders.

reading the interviews several times to get a sense of the content, the text was divided into meaning units corresponding to the study's aim. The condensed meaning units were thereafter sorted into preliminary categories (Catanzaro, 1988) according to similarities and differences in content. These were later subsumed into final categories, and analysed in relation to the identified themes, or threads of meaning that recurred in category after category (Baxter, 1994). Throughout the process, we occasionally referred to the original meaning units and compared the results of our analysis. Lastly, we reread the interviews to verify our results and to validate the themes. During the whole analysis process, all authors were involved and the interpretations were discussed until consensus was obtained.

2.4 | Ethical considerations

We conducted the study in compliance with the ethical principles of the Declaration of Helsinki (World Medical Association, 2013) and the General Data Protection Regulation. Before conducting the study, ethical approval was obtained by the Regional Ethics Review Board (Dnr. 2018/171-32). We informed all participants that their participation was voluntary, that they could withdraw from the study at any time, and that confidentiality and their anonymous representation in the findings were guaranteed. All participants provided their informed consent.

3 | RESULTS

The analysis revealed six themes (Table 2), as described in the sections below and illustrated with quotations from the interviews.

3.1 | Living with unpredictable pain

Women with WAD described experiencing pain as well as tenseness throughout their bodies every day. As the nature of their pain had changed and could not always be attributed to specific activities, the women had been unable to plan their days in advance and feared that the pain would dominate their day-to-day lives:

TABLE 2 Overview of themes ($n = 6$)**Themes**

Living with unpredictable pain

Trying to manage the pain

Living with limitations

Being unable to work as before

Needing support and understanding

Learning to live with limitations

When I get this intense pain, I actually cannot talk; I can't breathe—I do not know what to do. I actually just want to disappear. (P5)

Directly after their accidents, none of the women had attributed their pain to the accidents and, as a result, did not promptly seek medical help. However, as the pain changed and intensified afterwards, the women began to experience limitations in their daily lives, as the pain resulted in impaired balance, sensitivity to sound and light, low spirits and trouble with sleeping:

You don't have the strength to be [a] mum or wife or something; you get irritated and fatigued more easily. (P1)

Apart from the pain, wry neck and numbness had influenced these women's sleep and resulted in their being awake and active at night. All participants reported resting during the daytime in order to compensate for their lack of sleep at night, as well as needing days when they could relax in order to manage the pain:

I want to do so much, or my brain wants to do things, but my body doesn't get along with my mind. It's hard for a person. I have pain; I have illness. I know that, but at the same time, it's like it isn't me. It's hard to describe the odd feeling of not recognizing myself in the person who I am. I take painkillers and keep on going, but at the same time, my body is completely exhausted. (P6)

3.2 | Trying to manage the pain

All of the women reported taking painkillers or sleeping tablets in their search for peace and relief from the pain. Many had long experimented with medication in order to identify effective drugs. Although they had feared becoming dependent on painkillers, they also described that the painkillers afforded them a wonderful feeling of being free from pain:

Sometimes I can feel that the pain is getting more intense, and I try to prevent that by taking painkillers.

Then I can get relief, but if I don't get the tablets in time, the pain gets so intense that nothing actually helps. (P4)

In their quest for pain relief, all of the women had also experimented with different kinds of training. Initially, they exercised according to a programme prescribed by a physiotherapist; however, the exercise only increased their pain. Although treatment and rehabilitation for pain have undergone major changes over the years, the women described the difficulty of evaluating the help that they had received from a long-term perspective. In any case, they had been forced to learn to manage their pain, and structure their daily lives around it:

You have to manage it [the pain] because you can't get rid of it. You have to accept that you have pain. Even though I don't think that I will ever fully accept it, I have to choose to live with it instead of fighting against it. (P7)

3.3 | Living with limitations

The women with WAD additionally described not having the strength to perform housework as they had before and, in turn, having to ask other family members for help, which made them feel guilty. Some of them reported having to rearrange their homes as well, but ultimately finding solutions to make their lives easier. Immediately after their injuries, the women had performed housework as usual, despite increased pain and fatigue; in time, however, they learned to prioritize chores and perform housework depending on how they felt. Addressing that topic, one of the women said:

Everything takes a long time for me because I don't have the strength to do everything all in one day. (P3)

The women expressed feeling sad, no longer having the energy to engage in activities as they had before, and experiencing disappointment and anger due to their feebleness. They had not only placed demands on themselves and wanted to be as capable as before, but also experienced demands from their environments. Although they had learned to live with their limitations and adapted their daily lives in response, they also wished that their daily lives could be as they had been when they were healthy.

The women with WAD also described no longer being able to participate in leisure activities with the rest of their families. Instead, they had sought activities that the whole family could enjoy together. As some of them remained afraid to drive a car, they had been unable to take their children to school or on field trips. At the same time, they characterized the demands of their children's schools as too burdensome to manage. They tolerated a low level of stress, and described feeling frustrated and angry in response to all of the demands that

they felt had been imposed upon them. Eventually, however, they had learned to give priority to their children, rather than their anger:

Life has to go on; you can't just lie down and give up. But it's hard to realize that the things you easily managed previously now cause so much pain. The joy of doing things has run out of me, but we [my family] have found fun things to do anyway. I feel that my family is whom I want to be with most. (P2)

The participants added that their social lives had been affected by their lack of strength, and that they had lost contact with colleagues due to being on sick leave. They also expressed the need to be alone during periods of increased pain, when they lacked the energy to socialize with others. Moreover, their sensitivity to sound and light had restricted their capacity to be among large groups of people, which had negatively influenced their husbands' social lives as well as their own. Although they described their relationships with other adults as being important, they had had to choose to associate with friends with common interests, and consciously to avoid people who failed to understand their condition:

You choose the people around you who are kind and don't ask questions. You have to avoid those who are prone to hurt your feelings, because you don't have the strength to get sad or hurt. (P4)

3.4 | Being unable to work as before

Some of the women had been on sick leave since their accidents, whereas others had repeatedly returned to work, only to leave again or else undergo training for work. Invariably, their reasons for being on sick leave had been the pain they were suffering, and the fact that their jobs had become too physically demanding. For the women who had returned to work, their jobs had drained them of all strength, which had caused dissatisfaction with their quality of life. Nevertheless, all of the women reported wanting to work, and that their goal had been to return to work:

Work means a lot: to feel needed, and then there's the social aspect. Even though it's tough [at work], you feel and manage better after talking to colleagues and managing tasks together. (P6)

Although the women believed that they could return to work as long as work tasks were adapted, they remained unsure about whether their employers could accommodate them and about what would happen if they lost their jobs:

I need easier tasks at work as there are a lot of things I can't manage by myself ... for example, during the night

shifts to work alone—I just can't fix it. But it depends on how willing the employer is to stand up for me. (P1)

Stress and anxiety due to limited capacity to work saddened them, while requesting extended sick leaves made them feel guilty. At times, when they had lacked the energy to argue with the Social Insurance Office, they had received a clean bill of health and returned to work, despite lacking the necessary strength. As their work was important to them, they expressed sadness and disappointment with their situations, as their incapacity to manage their jobs had made them feel incompetent. One of the women who had completed her studies shortly before her accident said:

It was a great sorrow because, in the first place, I had finished my studies. I'd been qualified for only a year when the accident happened, so I never had time to settle into my new role at work. (P2)

3.5 | Needing support and understanding

The women with WAD indicated that their families and friends had provided the best support—indeed, the only support—because of delays in being diagnosed, receiving proper rehabilitation and developing good relationships with healthcare personnel. The women's families had placed demands and expectations upon them but also accepted that the women felt different from one day to the next. They also described the challenges that their disorders had caused for their children, who, over time, had learned that their mothers could not always be there to support them. Their husbands had offered outstanding support as well, not only with performing housework but also in contacting various authorities.

Despite support from family and friends, the women described the difficulty of discussing their feelings with them, and worried that they would grow tired of hearing about their illness. For that reason, they had sought support from medical social workers, for whom they expressed tremendous gratitude. Furthermore, once the women had finally met them, staff members at the pain rehabilitation clinic had been excellent sources of support as well. At the clinic, they had also met others in situations similar to theirs and with whom they had been able to share their experiences, and this had provided them with invaluable support in managing their daily lives:

They [staff members] were so good at listening at the rehab clinic. It felt so good. You were supposed to think positive, and it felt so good. (P1)

Although they also described initially encountering distrust and a lack of knowledge about WAD among others, they had found that increased knowledge about the illness had led to increased support and their general satisfaction with their current situation. The women

attributed the invisibility of WAD to the distrust that they had experienced from colleagues, employers, the Social Insurance Office and insurance companies. As well as co-workers being sceptical that such young women could sustain injuries that affected their ability to work, employers had also complained about their inabilities and compared them with others on sick leave. As examinations (e.g., X-rays) did not reveal any physical changes due to their injuries, the woman had also encountered disbelief among authorities, and many had struggled to gain the recognition and acceptance of their injuries. They described the lack of acceptance as being exceptionally disempowering, which had affected their mood, and some had even sought help from lawyers in their quest for justice:

The X-rays don't show anything, and that's a bit sad, I think, because then it's even harder for others, and for employers, to understand why you have the limitations that you have. (P7)

The women also described encountering general distrust about WAD from people around them. They reasoned that their own emphasis on appearing healthy, despite their pain and limitations, had inadvertently increased the invisibility of their illness. Consequently, others had expected them to be able to perform as they had before:

It's a struggle all the time ... to prove that you feel ill. It's hard to be accepted by others; they're so judgemental. (P5)

3.6 | Learning to live with limitations

The women with WAD described becoming people other than who they had been before the injury. Previously, they had been active and talkative, whereas they had become subdued and more reserved since experiencing WAD. Some described the shift in identity as being difficult to accept, as well as disappointing because it had made them old before their time. They hoped for recovery and for the discovery of a method that could relieve their pain:

I'm gradually starting to understand, after all these years, that I'm not the same as I was before, and never will be. (P3)

You don't have anything to lose by doing things. You just have to find a way to live, to slow down and to accept. (P2)

The women indicated that accepting their situations, and realizing that feeling good should be their top priority, they had tried to do what felt good to them. They also expressed that they no longer cared about what others thought about them and that, despite their

limitations, they were leading good lives and feeling happy. They added that engaging in fun activities, even ones that had intensified their pain as a result, had been important to motivating them, and they reported feeling better physically when thinking about things other than their pain and limitations. Nevertheless, they had sometimes felt guilty about being ill, and, as one said:

The will to be someone and to mean something is important but difficult to maintain now. (P5)

4 | DISCUSSION

Our study revealed that the women with WAD had lived with unpredictable, daily pain that they feared might dominate their lives. In other research, Råheim and Håland (2006) observed that people with chronic pain struggle to prevent pain from taking control of their lives. As daily activities reflect a person's interests, abilities and experience, limitations in performing these activities serve as daily reminders that one's abilities have diminished, and cause feelings of being trapped in a body without energy (Alsaker & Josephsson, 2003). Bodily restrictions can also prompt alienation from one's body, as it no longer functions as desired (Toye et al., 2016).

More particularly, our results indicate that the women with WAD had struggled to balance their daily activities with their pain. Addressing that relationship, Juuso, Skär, Olsson, and Söderberg (2011) found that unpredictable pain is more difficult to manage than pain related to certain activities, and Leder (1990) observed that chronic, unresolved pain demands the sufferer's ceaseless, concentrated attention. Both of those trends also emerged in our study, in which women with WAD reported struggling to find ways to manage their daily pain, so that they could get enough rest. In other recent studies, Ritchie et al. (2017) found that people with WAD had to experiment with various methods of managing their pain, before ultimately engaging in the self-management of symptoms that could not be cured. More theoretically, Richmond, Thompson, Deatricks, and Kauder (2000) characterized trauma as both the event that changes a person's life and the starting point of their journey to recovery. In that case, however, it is important that nurses and other healthcare professionals understand what recovery means to each person, in order to provide support tailored to accommodate his or her distinct needs, expectations and circumstances.

The women with WAD reported trying to alleviate their pain by various methods and, over the years, learning to manage the pain and find structure in their daily lives. In earlier studies, Juuso, Skär, Olsson, and Söderberg (2014) and Rutberg, Öhring, and Kostenius (2013) found that following routines and learning to live to pain allowed people with chronic pain to manage their day-to-day lives. Each woman with WAD in our study had learned what her body could manage, and that engaging in less strenuous exercise was one way to reduce the pain. The latter finding confirms the results of Southerst et al. (2016), who reported that exercise alone can improve

the management of neck pain among people with WAD. In clinical settings, therapy for WAD indeed requires healthcare professionals to learn how to understand what the disorder means from one patient with WAD to the next (Williamson, Nichols, & Lamb, 2015). At the same time, drawing on the findings of Coppieters et al. (2017) that women with traumatic chronic neck pain report greater pain-related disability than those with nontraumatic neck pain, healthcare professionals should adopt person-centred approaches in customizing recommendations to suit each person's individual needs. Moreover, as Richmond et al. (2000) suggested, healthcare professionals should also offer uniform instead of anticipatory guidance, the latter being shown to hinder the recovery of people with trauma (Richmond et al., 2000).

Among our other findings, the women with WAD reported being forced to live with limitations. They had not only placed demands on themselves to be as capable as they had been before, but also felt stressed by the demands of others. Although being unable to meet demands, whether of oneself or others, comes with a sense of worthlessness, support from others can compensate for those negative feelings and promote a sense of being valued (Strandmark, 2004). Biguet et al. (2016) found, however, that people with long-lasting pain who continually need support from others can experience guilt which can, in turn, prevent them from accepting that their lives have changed.

For the women with WAD in our study, leisure activities with family and work activities had been challenging because of their lack of strength to participate. Meanwhile, their lack of energy had negatively influenced their social life, and also that of their husband. According to Årestedt, Persson, and Benzein (2014), for persons with chronic illness, living from day to day becomes less impulsive, which affects the entire family. Outside the family, social isolation is a major feature of chronic illness, and maintaining normal relationships and mobilizing resources can be difficult, especially at work (Bury, 1982). Our results suggest that, despite their willingness, women with WAD could not work as they had before. Nevertheless, as Palstam, Gard, and Mannerkorpi (2013) have shown, for people with chronic illness, working is a way to live a normal life, and working with other people can afford a sense of belonging and opportunities to share experiences. By contrast, being forced to leave work can precipitate a sense of loneliness, sadness, loss of identity and worthlessness (De Souza & Frank, 2011). The results of our study reveal similar experiences, as the women had returned to work, only to discover that their jobs were more challenging, if not impossible. This finding supports the claim of Richmond et al. (2000) that recovering from injury is a complex, ongoing process in which the person solves problems, only to face new ones.

In our study, women with WAD reported difficulty in discussing their feelings with family and friends, as they worried that these individuals would grow weary of listening to this. Given their withdrawal from participating in social life, chronically ill persons can be discredited by their peers, and supportive partners can mitigate this by comforting them about lost attributes and abilities, as well as by emphasizing the positive aspects of daily life (Nilsson, Lindberg,

Skär, & Söderberg, 2016). As Richmond et al. (2000) posited, support from family can indeed facilitate an injured person's progress in recovery.

Nevertheless, family members rarely know what to expect from WAD, although the healthcare personnel who treat patients with WAD are well positioned to provide guidance. Even then, however, although the women in our study had been supported by pain rehabilitation teams, and had been relieved to meet others in situations similar to theirs at the rehabilitation centre, they had initially encountered distrust and a lack of knowledge due to the invisibility of WAD. Being met with such distrust from healthcare personnel is common when illnesses are undiagnosed or imperceptible, if not both. As Juuso, Skär, Sundin, and Söderberg (2016) and McGovan, Luker, Creed, and Chew-Graham (2007) have shown, the invisibility of the illness can make individuals with such disorders seem unreliable and without credibility, which can threaten their integrity and, in turn, fuel struggles to preserve their dignity (Söderberg, Lundman, & Norberg, 1999).

Finally, the women with WAD indicated that they had learned to accept their situation. However, they had struggled with accepting their new identities, been disappointed about being injured and felt old before their time. Their acceptance can be facilitated by the legitimization of others, and as patients struggle to acclimatize to their new lives (Richmond et al., 2000), it is important that healthcare personnel understand how they understand their pain and expectations of recovery.

4.1 | Limitations

For our study, we selected a purposive sample of individuals who had experienced the phenomenon under study—that is, WAD—and were willing to narrate their experiences (Polit & Beck, 2016). Seven women participated, and the sample size was considered to be sufficient because the interviews collectively exhibited variation and depth. Indeed, participants shared rich descriptions of their experiences, and the power of the information was sufficiently reflected in the variety of experiences articulated, which enriched our in-depth analysis of the interviews (Malterud, Siersma, & Guassora, 2016). According to Sandelowksi (1995), a sample should be large enough to give variation in experiences but small enough to permit deep analysis. At the same time, a small sample can be a limitation if the participants contribute to so-called “elite bias” (Sandelowksi, 1995), which reduces the generalizability of the results. Although our findings cannot be generalized, they nevertheless afford insights into the experiences of women with WAD which can be transferred to similar situations in other contexts (Polit & Beck, 2016). Nevertheless, the variation in the interval between the participants' accidents and the interviews, as well as the fact that the authors are registered nurses and researchers with preunderstanding of patients' experiences with chronic illness, may have affected the results. The lack of specific information regarding participants' characteristics can be a limitation. For ethical reasons, however, we chose not to include this, as the

small sample size of the participants, all of same gender and recruited from the same rehabilitation centre, would jeopardize the confidentiality and anonymity of the results, as promised to them in accordance with ethical obligations. Another limitation to the study might have been that no external reviewers were involved in the data analysis process. We did, however, bear this in mind throughout our analysis, and often returned to the interview transcripts to validate and confirm our results.

5 | CONCLUSIONS

Our findings revealed that living with WAD was affecting the lives of women with these disorders in multiple ways. The unpredictability of their pain reduced their strength, as well as limited not only their abilities to perform daily activities, but also the scope of their work and social lives. The women needed support and understanding, and, although they expressed satisfaction with their current lives, they had previously faced a lack of trust, knowledge and acceptance from healthcare personnel, authorities and others in their environments, which had affected their mood. Therefore, to meet the needs of women with WAD and provide appropriate resources to them, healthcare personnel should support their complex recovery processes by adopting person-centred approaches which enable the women to participate in their recovery, with relevant support based on their individual needs and circumstances.

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CONFLICTS OF INTEREST

All authors declare that there are no conflicts of interest.

AUTHORS' CONTRIBUTIONS

P.J. collected the data. All authors contributed to the analytical process. All authors drafted the manuscript, revised it, in collaboration, and approved the final manuscript.

ORCID

Päivi Juuso <https://orcid.org/0000-0002-7388-069X>

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