Women's perceptions of perineal repair as an aspect of normal childbirth

Abstract

Aims and objectives: The purpose of the study was to explore women's perceptions of perineal repair as an aspect of normal childbirth.
Design: The study design was qualitative and used interpretive phenomenology.
Participants: 11 nulliparous women were recruited. Of these, 10 sustained a 2nd degree tear and one had a posterior vaginal wall tear. All care was undertaken by midwives.
Results: Women accept perineal repair when it is managed correctly, their satisfaction is improved when they are given relevant information. Women place as much significance on the lead up antenatally and their recovery afterwards as they do to physically being sutured.
Conclusion: Antenatal services fail to adequately inform about perineal repair and women's preconceptions are affected by their peers. The transition to motherhood for women who feel fully informed is smoother. Women with unresolved questions about their repair, tend complain of increased pain, make unnecessary alterations to everyday hygiene tasks and rely more on their partners.

Keywords: Perineum, Perceptions, Repair, Transition

In the UK 85% of vaginal deliveries will result in a woman sustaining some degree of perineal trauma, of which two thirds will require suturing (Bick et al, 2010). Simple perineal trauma is classified as; a first degree tear, where there is only damage to the perineal skin, or a second degree tear, which involves trauma to the skin and perineal muscle (Fernando and Sultan, 2004). More complex tears, which are usually repaired by a senior obstetrician are defined as a third or fourth degree tear. As midwives are the lead professional at the majority of births, they are the practitioners who undertake the crucial role of perineal assessment post birth.

Midwives in the UK who have received sufficient training are expected to carry out the repair of first or second degree tears, and episiotomies (Tohill and Kettle, 2013). The aim of perineal repair is to achieve haemostasis and prevent infection, assist with wound approximation and to promote healing by primary intention. It is important that wherever possible, midwives undertake perineal repair as it maintains continuity of care, which has been found to make the experience less stressful for women (Royal College of Midwives (RCM), 2012).

Qualitative research has been undertaken to explore the psychological impact of repair. A study by Herron-Marx et al (2007) focused on women's experiences of postnatal morbidity. The women studied varied greatly; from those who saw their morbidities as an accepted part of childbirth, to those who felt so aggrieved by their health complications that their experiences affected their sexual, and social lives. For some women, their morbidity caused extreme psychological trauma. The women expressed dissatisfaction with postnatal services, and even those who normalised their morbidity felt more should have been done by professionals. Women felt a sense of responsibility for their issues, expressing the belief that they should have spent more time undertaking pelvic floor exercises, and were unable to seek medical help for fear that they would be stigmatised by practitioners.

There is a small body of research examining women's perceptions and feelings during the early postnatal period. A qualitative study from Brazil by Francisco et al (2011) examined women's experiences of perineal pain. They found no link between pain levels in relation to parity, ethnicity, mode of birth or episiotomy. There was, however, a link with age; with women over the age of 30 reporting much higher levels of pain. While there was no significant difference noted in the mode of birth, the authors acknowledged that in Brazil, women are far more likely to have an episiotomy performed. In the study, 80% of women who had an episiotomy complained of perineal pain compared with 56% without.

There is a distinct lack of research into women's experiences of the suturing process itself, especially where the degree of trauma is minor and undertaken by midwives. Green et al (1998) found that some women find suturing a traumatic experience; describing it as the worst part of their birth. Another study by Sanders et al (2002), found

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that women without regional analgesia reported high levels of pain during the procedure. They found that for some women, the pain immediately before birth and during the suturing process is extremely intense, and that even using hot/cold packs in labour or undertaking perineal massage in the antenatal period cannot improve, or prevent, it. They also found that the doses of local anaesthetic prior to episiotomy or suturing, varies greatly between practitioners, resulting in women complaining of severe pain. The RCM (2012) have recognised that additional investigation is needed into ensuring women are properly anaesthetised.

A qualitative study by Salmon in 1999, acknowledged that there was limited insight into whether women's psychological needs are being addressed during the process of suturing. This research highlighted women's dissatisfaction with the care they received at birth, and in the subsequent months. Women reported a lack of control and complained of not being listened to. Women frequently emphasised the gender of the practitioners caring for them, and some felt that being sutured by a man impacted on their repair. Women reported pain during suturing, and felt that it was ignored by male doctors. Overall, women resoundingly attributed uncompassionate care to a lack of skill and competence.

The available literature highlighted the intensity of some women's negative feelings towards this part of their birth, and further research to understand how to improve this aspect of their care is greatly needed. It was with this in mind that the research question was formulated: What are women's perceptions of perineal repair as an aspect of normal childbirth?

Methodology

A phenomenological methodology was chosen, as it is particularly suited to exploring the 'lived' experience, and is often used in health to examine a patient's understanding of their care (Parahoo, 2006). Phenomenology encourages deep insight into the experiences being studied, which means that resulting recommendations for practice are patient-focused and evidence-based.

Details of the study aims and objectives, along with the participant information sheet, were cascaded to midwifery staff and patients. The information documented in the woman's hand-held postnatal record allowed the community midwife to identify potential participants. Women were given at least 24 hours to process the study information, before being asked if they were willing to take part. The women were then contacted by telephone by the co-researcher within 2 weeks to answer any further questions. If the woman still wished to participate, a date to visit her at home was agreed. All procedures and interviews were performed in compliance with relevant laws and institutional guidelines. Ethical approval was obtained from a local ethics committee prior to recruitment. Approval was also granted from the research and developmental department at the study site.

Sample

All participants had a spontaneous vaginal birth at term; between 37 and 42 weeks gestation. The lead professional throughout the birth and suturing was a midwife. Women who sustained a first/second degree tear, posterior vaginal wall tear, labial lacerations and episiotomy were suitable to participate. The final sample consisted of 11 women. They were all interviewed within a month of birth except for one who interviewed at 1 month and 1 day as she had other commitments and had to reschedule the interview.

Analysis

The analysis for this study was based on thematic content analysis. Interviews were transcribed, then read and re-read to obtain a sense of the text as a whole. Transcripts were divided into separate units (codes) that represented alternative meanings; so that they could be expressed in more general ways. The codes were grouped to form categories that were similar or contradictory to other participants. The categories were examined and linked together to form themes. Software programmes were not used as they were deemed unnecessary due to the size of the study. The analysis was reflective and acknowledged that the co-researchers background as a midwife may affect the quality of the data obtained and the level of analysis undertaken.

Interviews were unstructured and in-depth and participants were encouraged to discuss areas of their experience that they found meaningful.

Results

Theme one: the mystery of perineal repair

One of the first things that became apparent was that the women were unaware of the reasons why perineal trauma could occur:

> ***'I don't know if any of it was me, if I pushed and shouldn't have pushed or if it's the way, 'cause they say sometimes, it's the way the head comes out don't they? I don't know if it was that or the position of his head. I actually don't know.' (Rachel)***

For the majority of the women, the physical technicalities of perineal trauma and the complexities of repair remained shrouded in uncertainty. The women here placed great significance on antenatal information given to them by friends and relatives. The experiences women reported being told were almost all negative, and most cases gave the impression that suturing was frightening and degrading. One woman was so worried after hearing other people's stories, that she described herself as 'heartbroken' when she was informed she needed stitches.

'I've had friends that have ... been wheeled in and left in surgery for ages and haven't been able to see their babies and so I suppose you think of tearing in that sort of extreme ... I didn't really think you could just tear a little bit, all I had ever heard was it just severe if you did tear.' (Helen)

When it came to information being provided by midwives at birth, a few of the women did comment that they had received some information on perineal trauma/repair.

'She said it wasn't a bad one. She said it was just a slight tear, and then when I was being stitched up I asked her about it and said, 'do you know how many stitches I am going to need?', and she just said it was like one continuous one, and that it wasn't particularly very deep and that it shouldn't take that long to heal. So, yeah it didn't, from what I was hearing it didn't sound bad.' (Helen)

The trend, unfortunately, was that the women were unable to recall or repeat the information about their tear or the aftercare advice given. Some of the women complained specifically of insufficient information or of it being given at a time close to birth which they were unable to remember.

'There was only one [antenatal class]. It was just the labour and birth one for an hour and they just basically talked about at what point to go to the hospital, what it will feel like and stuff. There weren't really much about what if I tear and this stuff happens.' (Liz)

Although perineal trauma is a regular consequence of birth, if women are unaware of this they may question their experiences and have misunderstandings about the physiological reasons why trauma is sustained. Only one woman made reference to the fact that it could be attributed to the perineum's ability to stretch and one other acknowledged that the incidence could be increased if the baby was born in a malpresentation (Fernando and Sultan, 2004). Women believed other reasons for trauma included: small stature, pushing incorrectly or wanting to deliver baby quickly. In two cases, the baby itself was blamed.

The majority of women stated they would rather not know about their trauma and had avoided detailed discussion, most stating they would be reluctant now to touch or observe their own perineum.

'I don't want to say ignorance is bliss because I had read a lot about everything else ... no probably ignorance is better actually. You don't need to go into that much detail do you? Yeah we will go with the ignorance.' (Helen)

Theme two: perineal repair and the transition to motherhood

The women in this study can be divided into two groups; those who found that their postnatal experience was greatly affected by their stitches and those who suffered no morbidity at all. While most felt their recovery was straightforward, four of the women expressed their shock at the impact suturing had.

'I'm sure people said it was all over once you've had the baby! Obviously I'm not still wiping as I would have wiped, I just dab and I try and go in the shower every day. I've not been in today because I daren't go in until (partner's) back and we haven't got a bath you see or I would have had a bath. But when I got home I couldn't hardly sit down I couldn't. I'm sitting on a blanket now 'cause it's so uncomfortable to sit down. Nobody told me how painful it would be.' (Rachel)

Helen discussed the way her relationship with her partner had changed and how they were unprepared for the amount of help she would need physically and emotionally.

'It was more painful than I thought ... Me and [partner] have both said that we were shocked by the whole experience,

you know, you expect to go home and look after your baby, you don't expect to go home and look after me. Your whole relationship changes I think, I don't know how single mums do it, I don't. You do need a lot of help afterwards I was surprised at the sort of aftermath and effect it had on me. I needed looking after when I came home I couldn't do anything, he literally had to bring me food and you know, help me to get down the stairs.' (Helen)

The women who felt most affected tended to be those who were interviewed very soon post-birth. Half the group had the conflicting view that their stitches had been of little impact on their transition to their new role. Many referred to pain initially but felt it had resolved quickly with simple analgesia or nothing at all.

'I'd say quite quickly afterwards I felt ok, after a week and a half I did, but I do wonder if I have been lucky that I didn't have a bad tear because I know that some people that have had a bad tear have had to really sit still and not go out and have been in a lot more pain but for me no it hasn't affected me in any way like that.' (Katie)

Theme three: midwife facilitated repair, a completely 'normal' experience

As a midwife undertaking this research, one of the most striking findings was that some of the women were unaware antenatally that midwives could undertake a repair. About half the women asked stated that they had assumed that the repair would be done by an obstetrician, although none were able to justify this with an explanation.

'I probably would have expected a doctor. I would just imagine that it would be a doctor but I don't really know why.' (Samantha)

This common misconception was challenged by the women's experiences. Samantha went on to state:

'She obviously knew what she was talking about and I suppose, I kind of thought, do the doctors do it (suturing) as much as the midwives? I just sort of felt it was part of her job and she did it all the time and she was sort of in and out, and knew exactly what she was doing. Yeah and because it wasn't a particularly bad [tear], I suppose if it was particularly bad then you would go to a doctor wouldn't you?'

The majority minimised their degree of trauma because a midwife had undertaken the repair.

'I think it would have made it feel a bit more serious somehow [doctor doing sutures]. I don't know having the midwife stitch me up just made it feel like it was all part and parcel of what I had to go through.' (Katie)

Women were very accepting of repair, if they found it a positive experience. The women were realistic when it came to simple perineal trauma.

'I'd be surprised if anybody didn't have stitches. I would say most people would have to, I mean there is people that don't isn't there? But when you think of what you are pushing out!' (Dawn)

The majority of women made encouraging comments about how they were treated and showed how a positive relationship with the midwife affected their experience.

'[They] just said that it were better that they did do it [perineal repair] than leave it really but they know what they are talking about and you just put your trust in their hands. I mean you don't know anything else do you? You are literally putting your life in their hands but it's their job and they know what they are doing.' (Dawn)

Discussion

The anecdotal experiences women reported being told echo the findings of Salmon (1999), where women gave shocking recollections of poor practice suffered at the hands of medical practitioners. Whether the accounts given via the participants were accurate is uncertain, because the sources of these stories were not present at interviews. However, the information the participants gave of this historical care was detailed and recanted as fact. There is evidence by Lundgren et al (2005) stating that women place a significant emphasis on the relationship they have with midwives, and that negative experiences continue to be significant decades later. This can lead to women

wanting to discuss their experiences with peers to facilitate acceptance and to rationalise their feelings; which would explain the trend of friends and family members repeating their traumatic suturing stories to the women in this study. It is concerning to think that pregnant women are being subjected to this antenatally and that it is shaping their preconceptions and causing fear prior to birth.

When it came to information being provided by midwives, a minority of the women commented that they had received some information on perineal trauma/repair, although it failed to explain perineal trauma as a part of normal birth. Women were unable to describe the advantages/disadvantages of having perineal repair undertaken and some stated they had definitely not been told. This void of knowledge appears to echo research undertaken by Priddis et al (2013) where women emphasised a lack of information being given after they sustained severe perineal trauma. In this study, however, some of the women recalled midwives at the birth trying to explain the repair to them, or felt that they had some understanding based on the conversations that took place in front of them between the midwife and other health professionals. Unfortunately there was still a degree of confusion, with two of the women stating that more knowledge would have eased anxieties about perineal pain post-birth.

One way midwives can encourage women to think about the physiological complexities of birth is through the promotion of perineal massage. None of these women had undertaken perineal massage, with only one woman recognising the term. She expressed her belief that it was too much of a commitment for her to strongly consider. The majority of the women denied being told about it, despite there being research that recommends its use in pregnancy (Shipman et al, 1997; Labrecque et al, 1999; Eason et al, 2000; Davidson et al, 2000; Labrecque et al, 2000). One could argue that having some awareness of their anatomy antenatally might give an insight into the causes of perineal trauma in advance. Research by Ismail and Emery (2013) found that more than 60% of women were accepting of perineal massage; however, only a few were made aware of it by professionals and of those informed, less than 5% were able to give accurate details of technique. Labrecque et al (2001) found that most women found both the physical and psychological effects of undertaking perineal massage in pregnancy positive with some involving their partners in the process. Perhaps by introducing perineal massage into routine antenatal care the 'ignorance is bliss' attitude would be challenged, meaning women would be more accepting of discussions about their perineum and would challenge taboos.

The shock some women felt about their transition to motherhood, could be attributed to the accepted belief that taking a baby home is one of the happiest times of a person's life. When this is complicated by pain that isn't expected, it can be assumed that women could be left feeling angry or aggrieved. The major complaints were in relation to moving, sitting, changing and feeding the baby, or getting dressed. Liz felt she had struggled to meet the demands of everyday life and that household chores had suffered due to her pain. McQueen and Mander (2003) recognise that women have to deal with complex emotions in relation to their birth experiences and that processing these emotions in relation to everyday life can be extremely challenging. They advised that postnatally midwives should inform women how to deal with tiredness and fatigue, as both have been shown to have an impact on family relationships. This study signifies what a complex time this is physically and emotionally. Couples need information about changing relationships and signposting to supportive services where they can share their experiences and normalise them with other women. Other studies have shown that women can blame themselves for postnatal morbidity (Herron-Marx et al, 2007; Priddis et al, 2013). However, in this study only Liz displayed any feelings of blame, with the majority of women feeling that their transition was relatively smooth.

Women's perceptions that a doctor would be needed were completely changed once the repair was undertaken by a midwife. They expressed similar confidence and trust in midwives as care providers as other women did in a study by Bluff and Holloway (1994) investigating women's experiences during birth. Participants in this study praised the midwives for their speed and efficiency, and the general consensus was that because a doctor wasn't needed the group minimised their trauma and accepted its occurrence. This echoes the work of Priddis et al (2013) who similarly found that the behaviour of the person facilitating the repair affected how accepting women were of needing to be sutured. Women in a study by Salmon (1999) reported extremely poor experiences of interpersonal relationships during repair, describing them as 'cruel' or 'brutal'. This conflicts with the findings here where women praised the midwives and emphasised their trust in their knowledge and skills.

When you compare this study to work undertaken by Salmon (1999) and Sanders et al

Key points

- Antenatal services fail to inform about perineal repair and women's preconceptions are affected by their peers
- The transition to motherhood for women who feel fully informed is smoother
- Women with unresolved questions about their repair, tend complain of increased pain, make unnecessary alterations to everyday hygiene tasks and rely more upon their partners
- Midwife facilitated repair is deemed as a completely 'normal' experience
- The physical technicalities of perineal trauma and the complexities of repair remained shrouded in uncertainty

(2002) where women reported enduring high levels of pain during repair, the experiences the women reported here were much more pleasant. Every person interviewed, except one, felt that experiencing a repair was not a significant part of their birth. The women reflected on how well the procedures were undertaken, with midwives asking if they were properly anaesthetised. Sanders et al (2002) questioned whether the timing of their data collection would have affected the pain levels reported. They theorised that the women may have complained of increased pain during suturing as they were still recovering and experiencing postnatal pain. However, all the women in this study were interviewed very quickly post-birth and the timing of interview appeared to have no impact on the pain levels reported. The findings here suggest that even if women do experience some discomfort during the procedure they can accept it when the procedure is managed sensitively.

Strengths and weaknesses

Lots of women expressed an interest in participating in the study. The sample demographic was varied both in age and socioeconomic status. This has allowed for the study's findings to be reflective of the general population; with the exception of ethnic minorities, as all of the women were White British. All participants were interviewed quickly post birth, which meant that their recollections were likely to be clear.

This study was the researcher's first project and the interview technique and the analysis of data may not have been as in-depth as someone with experience, although supervision and guidance was regularly sought to overcome this. Another difficulty with this type of research is trying to ensure rigor. Member checking was offered to every participant and they were then followed-up via a message/phone call once the interview was transcribed. Four participants initially wanted to be involved but one later failed to respond to attempts to send them a copy of their transcript. Ideally, all participants would have taken part in member checking but due to the pressures of new motherhood it can be understood why they did not want to.

Conclusion

This study found that women are accepting of perineal trauma and repair as an aspect of normal birth, when it is managed sensitively. Women's satisfaction with the process is significantly improved when they are given sufficient information to be able to understand and rationalise their tear. Women place as much significance on the lead up antenatally and their recovery afterwards as they do physically being sutured. Current antenatal services fail to adequately inform women about the intricacies of perineal trauma and repair, and women use friends and relatives to shape their antenatal preconceptions. The transition to motherhood for women who feel fully informed about their trauma is smoother and those who feel they had unresolved questions tended to complain of more pain, make unnecessary physiological adaptations and rely more upon their partners. **BJM**

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