Experiences of women who have severe perineal trauma, their associated morbidity and health service provision in New South Wales, Australia: A mixed methods study

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Dedication

This thesis is dedicated to every woman who has experienced severe perineal trauma. To the women who participated in this research - I am humbled to have been present as you have shared your most intimate moments and memories with me. We have laughed together, we have cried together. I will carry your words, your faces, your stories with me, for a lifetime.
Acknowledgements

No matter how dark and hopeless I felt at times, my doctoral supervisors Professors Hannah Dahlen and Virginia Schmied were my beacons of light. You both continue to see amazing things in me that I hope one day to see in myself. Words cannot express my sincere gratitude for your warmth, guidance, endless belief and support; the hugs, the tissues for my tears, the emails, and the phone calls. For supporting me to honestly and sensitively represent the stories of women who have experienced severe perineal trauma. To Professor Christine Kettle and Dr Anne Sneddon – two of the most beautiful women who have embraced me, comforted me, understood and supported me. You are both gifts.

During the darkest moments my husband, Luke, you and the children were my only happiness; never questioning, always supporting. Thank you for your patience, for your love, for understanding that I must chase my dreams, to live my life with passion, and bring about change for these women. To be loved is the greatest gift, and I know that I am adored by you, as I adore you (I love you more!).

To my children – Steve, Amber, Cooper and Kaia. Thank you for being so patient while I did my “uni work”. You are my motivation and I am blessed to be your mum.

To my closest of friends and colleagues – Emma, Amiee, Katie, Elaine, Mellanie, Margie and Kim. Every single one of you has supported me through this journey. Each and every one of you are amazing women who I am blessed to have in my life.
“...And my mother will stare into the starlanes,
the endless tunnels of nothing,
and as she gazes,
under the hour's spell,
she will think how we yield each night
to the soundless storms of decay
that tear at the folding flesh,
and she will not know
why she is here
or what she is prisoner of
if not the conditions of love that brought her to this...”

“My Mother On An Evening In Late Summer” by Mark Strand 2007
Statement of Authentication

The work presented in this thesis is, to the best of my knowledge and belief, original except as acknowledged in the text. I hereby declare that I have not submitted this material, either in full or in part, for a degree at this or any other institution.

..........................................................

(Signature)
Outcomes of this thesis

This thesis is presented as a series of four published papers and one paper which is currently under review. I am the first author of all the papers and was responsible for, and contributed towards, collecting and analysing the data that are reported in each paper. One paper, of which I am second author, is attached as Appendix A, as it provides supporting information. I prepared the first full draft of each paper and my research supervisors provided feedback on each draft. My supervisors contribution involved collaborating on the design of the study, confirming of auditability of the data analysis and providing assistance and direction in re-drafting or extending the content of each paper.

Publications


Presentations

5. The 8ʰ Normal Labour and Birth Conference, Grange-over-sands, Cumbria, United Kingdom. 5ᵗʰ- 7ᵗʰ June, 2013. “Severe perineal trauma: The voices of women - A mixed methods study”.

¹ The findings from a data linkage study examining trends and risk factors for SPT in NSW from 2000 – 2008, of which I am second author, will be used throughout the discussion in this thesis as supporting information, however this study was not part of the mixed methods research and is attached as Appendix A.
8. Westmead Public Hospital, Westmead, Sydney. 24\textsuperscript{th} October 2013. “Women’s experiences of severe perineal trauma”.

9. International Confederation of Midwives 30\textsuperscript{th} Triennial Congress. Prague, Czech Republic. 1\textsuperscript{st} – 5\textsuperscript{th} June, 2014. “Women’s experiences following severe perineal trauma: A mixed methods study”. 
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Ethics

This research was approved by the University of Western Sydney Human Research Ethics Committee on the 10\textsuperscript{th} of October, 2011 in a letter from Dr Anne Abraham, Chair, UWS Human Research Ethics Committee. The protocol number assigned to this research was H9298.
Glossary and Abbreviations

SPT – Severe perineal trauma
LHD – Local Health District
CMC – Clinical midwifery consultant
NSW – New South Wales
MDC – Midwives Data Collection
APDC – Admitted Patient Data Collection

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Abstract

Background: Severe perineal trauma (SPT) (third or fourth degree tears) sustained during vaginal birth, is associated with short and long term physical and psychological morbidities for women. Research conducted nationally and internationally indicates that the incidence of SPT is increasing, which is associated with increased rates of SPT and improved recognition and reporting by health professionals. However despite this, research on women’s experiences of SPT is limited, and the adequacy of support and health services available to women following SPT has not been examined. Developing an understanding of women’s experiences of SPT, and the current health services provided and accessed, will assist health professionals in the provision of appropriate models of care. This thesis is presented as a series of four published papers, and one paper currently under review. The findings of these studies contribute towards an understanding of women’s experiences following SPT.

Aim: The aim of this mixed methods study was to understand the experiences of women who have sustained severe perineal trauma (3rd and 4th degree perineal tears) and associated morbidities, and to investigate health service provision across NSW, Australia. This study had four objectives: 1) To describe the physical health, psychological, and social experiences for women who have sustained SPT; 2) To determine if there has been a change in the incidence of SPT in NSW over the past 10 years, and to identify the factors associated with SPT and the impact SPT has on subsequent modes of birth; 3) To describe the health services available for women who experience SPT in NSW; and 4) To provide an integrated analysis of the data to outline best practice to inform services for women.

Methods: This study used a sequential concurrent mixed methods design. A transformative-emancipatory auto-ethnographic approach was incorporated into the design, analysis and
preparation of the study as the author identified with the group under investigation following a personal experience of SPT and associated long term morbidities. There were four stages to this study.

1) The literature search, conducted between February and April 2011, aimed to identify qualitative research conducted over the past 15 years to identify current literature and landmark studies which explored the experiences of women who had sustained SPT. The literature was continuously searched and updated during the undertaking of the study for any new studies being reported. Of the 478 papers identified, only four papers met the inclusion criteria; three of the papers directly focused on perineal trauma, the fourth paper focused on pelvic injuries as a result of childbirth. Three overarching themes emerged from a meta-ethnographic synthesis of these four qualitative papers: “I am broken and a failure”, “Dismissed, devalued and disregarded”, and “The practicalities of the unpredictable perineum”. These overarching themes highlighted that there is a profound impact on the physiological and psychological wellbeing for women who experience SPT and associated postpartum morbidities due to childbirth.

2) Birth records in NSW between the period of January 2000 to July 2008 were analysed; this data included a total of 510 006 births. Outcomes for women who had experienced SPT during their first birth were compared to women who did not. Primiparous women who experienced SPT were less likely to have: a subsequent baby compared to those women who had not (56% versus 53%) (OR 0.9; CI 0.81-0.99); were no more likely to have an operative birth or another severe perineal tear in a subsequent birth (OR 0.9; CI 0.67-1.34), and were more likely to have a related surgical procedure in the 12 months following the birth (OR 7.6; CI 6.21-9.22).
3) In depth interviews were conducted with twelve women who had experienced SPT. The findings resonated with the overarching themes identified in the meta-ethnographic synthesis, and many similarities appeared in the analysed data. Three main themes were identified: ‘The Abandoned Mother’, ‘The Fractured Fairytale’, and ‘A Completely Different Normal’.

4) Interviews and a survey provided data on health service design from the perspective of NSW Clinical Midwifery Consultants. One overarching theme was identified: ‘A Patchwork of Policy and Process’, which identified that current health services operate in a ‘patchwork’ manner when caring for women who sustain SPT, characterised by a lack of consistency in practice and standardisation of care. This theme was further characterised by a discrepancy between the services that are provided and the needs of women. Within the overarching theme five subthemes were identified: Falling through the gaps; Qualifications, skills and attitudes of health professionals; Adding rural complexity to the picture; Caring for women who have sustained SPT; and Gold standard care: how would it look?

Findings: the central and key finding of this mixed methods study is represented by ‘The Abandoned Mother’ concept. It appears that, despite the long term psychological and physical morbidities experienced by women who sustain SPT, there is a lack of guidelines, policies and services specific to the care of women following SPT. This needs to be addressed as a matter of urgency. Women who experience SPT seek compassionate and supportive care based upon a clear exchange of information, and this should be considered when reflecting upon the current health service design. This study highlights the urgent need to establish specialist services across NSW that are comprehensive, collaborative and multi-disciplinary to support women who experience SPT and associated morbidities, with the aim of providing consistency in best practice and comprehensive physiological and psychological support.
Chapter One: Introduction

For many women and their partners, there may be no greater joy than when they discover that they will be welcoming a new child into the world. The physical transition that a woman experiences over the duration of her pregnancy, as the unborn baby develops and grows, may be accompanied by an intense emotional rollercoaster as she prepares to become a mother. Every day, as the woman and her unborn baby become intimately connected, hopes, dreams and expectations grow. But what happens when reality is far from these expectations and hopes; when experiences as a woman giving birth and being a new mother conflict with our culturally ingrained expectations?

When a woman experiences birth related trauma which may result in long term morbidities, she attempts to navigate an unexpected and unfamiliar normality. Birth trauma has been defined by Beck (2004) as: “…an event occurring during the labour and delivery process that involves actual or threatened serious injury or death to the mother or her infant. The birthing woman experiences intense fear, helplessness, loss of control and horror.” (Beck, 2004, p. 28). Such trauma includes caesarean section, severe perineal trauma, stillbirth or infant death, instrumental birth, postpartum haemorrhage, and emergency hysterectomy (Beck, 2004; Elmir, Schmied, Wilkes, & Jackson, 2011). Cultural and societal expectations may result in women with postpartum morbidities being socially isolated and stigmatised, unsure and fearful of when and where to seek support. As stated by Agnew 150 years ago: “Many females, from motives of delicacy, timidity, or hopelessness, carefully conceal such, suffering in silence the many evils which they entail” (Agnew, 1873, p.3).
This thesis explores the experiences of women who sustain SPT, experience associated morbidities, and the health services provided for such women. This mixed methods study explores the outcomes and experiences of women who sustain SPT, the impact of associated morbidities that can occur as a result of SPT, and their interactions with health professionals and health service provision. Further, this study explores the health services of NSW from the perspective of women and midwifery leaders (Clinical Midwifery Consultants (CMCs)). This research aims to understand the experiences of women who sustain severe perineal trauma (3rd and 4th degree perineal tears) and associated morbidities, and to investigate health service provision across NSW, Sydney Australia.

1.1 Trauma and the perineum

The short and long term physiological impact of perineal trauma can be understood through a description of the pelvic floor and associated structures which are connected to the perineum, of which the perineal body is the central point (Dahlen, 2010). The pelvic floor is the name given to the muscles, ligaments and tendons that connect within, and support, the structure of the bony pelvis; it is these elements that maintain the integrity of pelvic functions. These functions include supporting the pelvic organs, including the uterus and ovaries connected via the fallopian tubes, bladder and rectum. The structure and integrity of the pelvic floor is therefore crucial in maintaining both urinary and faecal continence (Prendergast, 2010; Steen, 2013). The perineal body is a triangular shaped structure between the vagina and the anal sphincter, consisting of muscles and fibrous tissue. In this area, the nerve supply stems from the perineal branch of the pudendal nerve, and the levator ani join – a pair of deep muscles (the pubococcygeus and the iliococcygeus) which provide a “sling” to support the pelvic organs,
and are important in maintaining urinary and faecal continence (C Kettle, 2010; Thakar & Fenner, 2009).

**Anatomy of the pelvic floor**

(Amy Stein, 2014)

Perineal trauma is defined by the extent of injury sustained to the perineum, skin, perineal muscles, labia, clitoris, urethra, and internal and/or external anal sphincter which may include the rectal mucosa (C Kettle, 2010). It is further classified into either anterior (labia, urethra, clitoris) or posterior (perineal muscles, anal sphincter, rectal mucosa) perineal trauma (C Kettle, 2010; C Kettle & Tohill, 2008). Severe trauma to the perineum can occur spontaneously or as a result of obstetric intervention during vaginal birth, including episiotomy, ventouse or forceps (Dahlen et al., 2007; Fernando, Sultan, Kettle, Thakar, & Radley, 2010). Severe
perineal trauma during childbirth is defined as a third degree tear, which involves injury to the perineum involving the anal sphincter complex; or a fourth degree tear, which involves injury to the perineum involving the external, internal and epithelium of the anal sphincter (RCOG, 2007). For the purposes of this doctoral research project, the Royal College of Obstetricians and Gynaecologists (RCOG) (RCOG, 2007) definitions of perineal trauma are used.

Definitions of perineal trauma (RCOG, 2007)

<table>
<thead>
<tr>
<th>Degree</th>
<th>Trauma to Perineum</th>
</tr>
</thead>
<tbody>
<tr>
<td>First Degree</td>
<td>Injury to perineal skin only</td>
</tr>
<tr>
<td>Second Degree</td>
<td>Injury to perineum involving perineal muscles but not involving the anal sphincter</td>
</tr>
<tr>
<td>Third Degree</td>
<td>Injury to perineum involving the anal sphincter complex: 3a: Less than 50% of EAS thickness torn. 3b: More than 50% of EAS thickness torn. 3c: Both EAS and IAS torn</td>
</tr>
<tr>
<td>Fourth Degree</td>
<td>Injury to perineum involving the anal sphincter complex (EAS and IAS) and anal epithelium</td>
</tr>
</tbody>
</table>

1.2 Incidence of severe perineal trauma

While it is reported that approximately two thirds of Australian women will experience some degree of trauma to the perineum during a vaginal birth, it is estimated that around 2.0% will experience severe trauma to the perineum (third or fourth degree tear) (Li, Zeki, Hilder, & Sullivan, 2012). The rate of severe perineal trauma is reported to range from 1.7% in Tasmania, to 3.6% in the Australian Capital Territory (Li et al., 2012). A data linkage study conducted in New South Wales (NSW) on all births from 2000–2008 found a significant increase in the overall rate of SPT from 1.4% in 2000 to 1.9% in 2008 (Dahlen, Priddis, et al., 2013). This increase was most notable in third degree tears and extensions following episiotomies (Dahlen,
Internationally, the incidence of SPT is reported to range from between 0.5 – 7%. This variation may be due to reporting processes, diagnosis and obstetric management, and differences in the definition of perineal trauma (Asheim, Nilsen, Lukasse, & Reinar, 2012; Byrd, Hobbiss, & Tasker, 2005; C Kettle & Tohill, 2008).

1.3 Risk factors for severe perineal trauma

Antenatal risk factors associated with an increased incidence of SPT include parity, maternal age, Asian ethnicity including women from India and Bangladesh, nutritional status, previous experience of perineal trauma, fetal weight and abnormal collagen synthesis (Dahlen & Homer, 2008; C Kettle & Tohill, 2008; Kudish, Sokol, & Kruger, 2008; Priddis, Dahlen, Schmied, et al., 2013). Intrapartum risk factors include fetal presentation, particularly a fetus presenting in the occipito-posterior position, medio-lateral and midline episiotomy, instrumental birth using ventouse and/or forceps, a prolonged second stage of labour, the birth position adopted by the woman during second stage, and an obstetric emergency such as shoulder dystocia (Dahlen, Priddis, et al., 2013; Eskandar & Shet, 2009; Gottvall, Allebeck, & Ekeus, 2007; Kudish et al., 2008; O'Mahony, Hofmeyr, & Menon, 2010).

1.4 Morbidity of severe perineal trauma

Complications experienced by a woman following perineal trauma are associated with the severity of the trauma and the use of appropriate repair methods (C Kettle & Tohill, 2008). Symptoms following SPT can occur as a result of neuropathy, disruption of the anal sphincter and extensive scarring of the perineum and anal sphincter. Following SPT, some women remain asymptomatic whilst others may experience any or all of the following symptoms: stress and/or urge urinary incontinence, flatus and faecal incontinence, haemorrhoids, dyspareunia, and the risk of developing additional morbidities such as vesico-vaginal fistulas and pelvic
organ prolapse (Bagade & MacKenzie, 2010; Pauls et al., 2007; Rathfisch et al., 2010; Tin, Schulz, Gunn, Flood, & Rosychuk, 2010; Wall, 1999). The exact incidence of short and long term symptoms as a result of severe perineal trauma is unknown. Stevenson (2010) identifies that under reporting by women is due to the nature of the symptoms, a statement further supported by Groom & Patterson-Brown (2002).

1.5 Prevention and management

In response to an increased awareness of the long term psychological and physiological morbidities that may occur as a result of SPT, research investigating the effectiveness of perineal management techniques has been undertaken with the aim of minimising perineal trauma and/or associated morbidities for birthing women. There is now Level 1 evidence available into the effectiveness of perineal massage, the use of warm packs applied to the perineum, and hands on or hands off/poised techniques. Additional research has explored the influences of birthing positions in the second stage of labour, and the use of episiotomies, on SPT outcomes. These perineal management techniques are discussed below.

Warm packs during the second stage of labour

A Cochrane review conducted by Aasheim et al (2012) examined the effectiveness of techniques used during the second stage of labour on the incidence of perineal trauma. Eight randomised studies were included, involving a total 11 651 women. These studies included research into hands off (or poised) versus hands on (3 studies), perineal massage versus hands off (two studies), warm packs applied to the perineum versus hands off or no warm packs (two studies), and Ritgen’s manoeuvre (one study). The meta analysis of these studies reveals that, compared with hands off or no warm packs, the use of warm packs are associated with a
significant reduction in the incidence of third and fourth degree tears (Aasheim, Nilsen, Lukasse, & Reiner, 2012). The authors further report a significant effect on perineal outcomes when perineal massage is used during the second stage of labour versus no massage (Aasheim et al., 2012).

Antenatal digital perineal massage

Benefits of antenatal digital perineal massage are also reported, with a Cochrane review by Beckmann & Stock (2013). These authors report a reduction in perineal trauma requiring suturing, episiotomies, and perineal pain following birth, when antenatal perineal massage is undertaken in comparison to no perineal massage. No significant differences were reported in the incidence of SPT, instrumental births, sexual satisfaction in the postpartum period, or of incontinence of urine, faeces or flatus (Beckmann & Stock, 2013). The benefits were mostly seen in primiparous women, and consideration should be given as to whether this practice is seen as appropriate for women from culturally diverse backgrounds. Limited evidence is available regarding antenatal digital perineal massage with a massaging device.

Hands on versus hands off/poised

Hands on technique involves the care provider placing their hands on the perineum and occiput of the crowning head. It has been suggested that this technique increases flexion to reduce the presenting diameter of the fetus, therefore minimising trauma to the perineum (Aasheim et al., 2012; Laine, Skjeldestad, Sandvik, & Staff, 2012; McClandish et al., 1998). However, the definition of hands off/poised varies; in general in the care provider keeps hands off and observes the birthing of the head and shoulders and supports the birthing of the body as required, or intervenes in case of emergency (Aasheim et al., 2012; da Costa & Riesco, 2006).
In a comparison of outcomes using hands on versus hands off/poised techniques for decreasing perineal trauma during the second stage of labour, a Cochrane review conducted by Aasheim et al (2012) reported that there was no difference in third and/or fourth degree perineal trauma outcomes between these two groups. It was further reported that hands off/poised is related to a reduction in the incidence of episiotomy. The authors note, however, that studies investigating the outcomes of hands off/or poised and hands on vary in the definition of hands off (hands off for the entire second stage, hands off only until head is crowned) (Aasheim et al., 2012).

It has been suggested that techniques such as the modified Ritgen’s manoeuvre, work against the normal physiological mechanisms of labour and therefore place into question the protective value of perineal support (Aasheim et al., 2012). There is no evidence to support the use of the Ritgen’s manoeuvre, which involves the health professional using the fingers of one hand to manoeuvre the fetal chin interiorly, while placing the other hand on the occiput of the fetal skull. This action is undertaken during a contraction, with the aim of maintaining flexion on the fetal head, and controlling the speed of delivery (Aasheim et al., 2012; Jonsson, Elfaghi, Rydhstrom, & Herbst, 2008).

**Birthing positions and the second stage of labour**

Current research investigating the impact of birth position on perineal outcomes report varying findings (Dahlen, Dowling, Tracy, Schmied, & Tracy, 2013; Priddis, Dahlen, & Schmied, 2012). A Cochrane review conducted by Lawrence et al (2013) reported on the effects of encouraging women to assume upright positions during the first stage of labour (walking,
sitting, standing and kneeling) versus recumbent positions (supine, semi-recumbent and lateral) on the duration of labour and type of birth. However, none of the included studies report the outcomes for second or third degree perineal tears (Lawrence, Lewis, Hofmeyr, & Styles, 2013). Further studies report an associated increased incidence of perineal trauma with the lithotomy position (Gottvall et al., 2007).

The effects of birth positions on the second stage of labour, without epidural anaesthesia, were explored in a Cochrane Systematic Review that included 20 randomised and quasi-randomised trials (Gupta & Hofmeyer, 2004). Upright positions included sitting, semi-recumbent (trunk tilted backwards 30° to the vertical), kneeling and squatting (unaided, using squatting bars or birth cushion). Amongst the outcomes, a comparison of upright or lateral positions with supine or lithotomy demonstrated a significant reduction in episiotomies (12 trials, RR 0.83, 95% CI 0.75 – 0.92), along with an increased occurrence of second degree perineal trauma (11 trials, RR 1.23, 95% CI 1.09 – 1.39). In this systematic review (Gupta & Hofmeyer, 2004), no significant differences were demonstrated when comparing upright to supine positioning with the incidence of SPT (4 trials).

In another systematic review conducted by de Jonge, et al., (2004) the risks of perineal trauma were examined amongst three groups: women in lithotomy, semi sitting or sitting positions for second stage. No significant differences were found between the groups. De Jonge et al (2004) suggest that this variation may have been due to the exclusion of studies in which professionals did not appear to be confident due to inexperience in supporting women in various birthing positions, in comparison to Gupta et al (2004) who included these studies. Evidence remains inconclusive as to the impact of upright birth positioning on perineal outcomes. It has been
suggested that inconclusive outcomes may be related to inconsistencies in defining upright positions (de Jonge, Teunissen, & Lagro-Janssen, 2004; Priddis et al., 2012).

In suggesting a position to a woman in the second stage of labour for purposes of observing the perineum where there is no identified risk, it is important to consider that freedom to change positions in labour is identified as integral to feelings of control and the management of pain in labour due to the physiological and psychological benefits (Coppen, 2005; de Jonge & Lagro-Janssen, 2004).

Are episiotomies protective of severe perineal trauma?

Discussion continues in current literature as to the impact of median and medio-lateral episiotomies on perineal outcomes. Episiotomies are frequently referred to in the literature as risk factors for SPT (Eskandar & Shet, 2009; Hartman et al., 2005). However, it has been suggested that medio-lateral episiotomies, performed as a result of a clinical indicator including fetal distress, are protective of SPT outcomes when compared to the use of routine episiotomies (Carroli & Belizan, 2000; Laine et al., 2012; Revicky, Nirmal, Mukhopadhyay, Morris, & Nieto, 2010). Therefore consideration should be given to the use of restrictive (clinically indicated) medio-lateral episiotomies over routine episiotomies in the clinical setting, with further research required.

Management of severe perineal trauma

Research has been undertaken as to the most appropriate and effective treatment methods for women who sustain SPT, with the aim of minimising short and long term symptoms including perineal pain, urinary, faecal and flatal incontinence, and dyspareunia (Buppasiri, Lumbiganon,
Thinkhamrop, & Thinkhamrop, 2010; Fernando et al., 2010; C. Kettle & Johanson, 1999; Nordenstam et al., 2008). It is recommended that a thorough assessment and evaluation of the degree of trauma to the perineum and anal sphincter be conducted immediately following the birth by a health professional who is trained in pelvic floor anatomy and correct suturing techniques (Groom & Paterson-Brown, 2002; McNicol et al., 2010; RCOG, 2007; Stevenson, 2010).

Research reports that when the assessment of the perineum is performed by inadequately trained staff, it can result in misdiagnosis of the degree of perineal trauma, and consequently result in inadequate and inappropriate treatment, morbidities such as wound breakdown and abscess formation, and the development of co-morbidities such as recto-vaginal fistula (Andrews, Sultan, Thakar, & Jones, 2006; Faltin, Boulvain, Floris, & Irion, 2005; Fernando et al., 2010; Giebel, Mennigen, & Chalabi, 1993).

Following assessment and repair, for women who sustain SPT it is suggested that the immediate postpartum care should include the administration of antibiotics to promote healing and prevent wound breakdown, appropriate analgesia for perineal pain, physiotherapy support and information (Buppasiri et al., 2010; RCOG, 2007). Following the immediate postpartum period, best practice models of care suggest that all women who sustain SPT should be referred for an endoanal ultrasound to determine the integrity of the anal sphincter and to identify an occult or missed trauma to the anal sphincter, consultation with a specialist or colorectal surgeon in locations where specialist perineal care clinics are operational, and where women can access supportive, collaborative care within the one facility (C Kettle, 2005; RCOG, 2007; Thakar & Sultan, 2007).
1.6 Women’s experiences of severe perineal trauma

Despite the extensive literature that is available on the risk factors, incidence, methods of repair and long term morbidities associated with SPT, there is a lack of research reporting on the experiences of women who sustain third or fourth degree perineal tears. While research has acknowledged that the morbidities that can occur as a result of SPT have the potential to impact upon a woman’s physical and psychological well-being in both the short and long term, the focus of research continues to be placed on minimisation of risk and treatment strategies. Current research appears to focus more on the dysfunctional perineum and associated symptoms that occur as a result of SPT, and less on the women who experience these symptoms.

1.7 Aim and objectives

The aim of this mixed methods study is to understand the experiences of women who have sustained severe perineal trauma (3rd and 4th degree perineal tears) and associated morbidities, and to investigate health service provision across the state of New South Wales, Australia. This study had four objectives:

1) To describe the physical health, psychological, and social experiences for women who have sustained SPT.

2) To determine if there has been a change in the incidence of SPT in NSW over the past 10 years, and to determine the risk of recurrence, subsequent mode of birth and morbidity for women who experience SPT.

3) To describe the health services available for women who experience SPT in NSW.
4) To inform service design, delivery and best practice when caring for women who experience SPT.

A sequential concurrent mixed methods design is used. In the initial phase of the study, a meta-ethnographic synthesis of studies reporting women’s experience of SPT was conducted. This synthesis informed the questions for individual interviews with twelve women who have sustained SPT during birth, with a specific focus on the care women received from health care services, and their interactions with health service providers/professionals.

Concurrently, a linked data population based cohort study was conducted to examine perineal outcomes for women who gave birth in New South Wales between January 2000 and July 2008 recorded in the Midwives Data Collection (MDC), to determine if there has been a change in the incidence in SPT over this time period. These births were then matched to Admitted Patient Data Collection (APDC) to determine the number of, and reasons for, any subsequent hospitalisations to quantify the burden of disease in women following SPT. The findings from these three studies then guided a discussion group and survey conducted with the Clinical Midwifery Consultants (CMCs) from each Local Health District (LHD) in NSW. The aim of this discussion group was to describe current health services provided to women in NSW who have experienced SPT from the perspective of CMCs.

1.8 Significance of the study

Although it is reported that the incidence of SPT is increasing both within Australia and internationally, the experiences of women who sustain SPT and experience short and long term morbidities remains relatively unexplored (Priddis, Dahlen, & Schmied, 2013). By examining population data, listening to the voices of women, and speaking to midwifery leaders, this
research aims to understand the experiences of women who have sustained SPT to facilitate an awareness of what constitutes appropriate and comprehensive care, what works well within the system, and what can be improved. This is the first mixed methods study in Australia which aims to develop a comprehensive understanding of the experiences for women who sustain SPT, the provision of health services for these women, and the impact of SPT on subsequent modes of birth, risk of recurrence and morbidities for women.

Findings from this study will provide the opportunity to enhance the knowledge and awareness of health professionals when caring for women who sustain SPT, and the impact that this birth related trauma has on a woman’s physical and psychological wellbeing. It is hoped that the findings from this study will contribute towards improving the care provided by health professionals and health services by informing the development of guidelines to improve and support service provision for women who sustain SPT in NSW.

1.9 About the researcher

As a woman and a mother of four children, I have sustained severe perineal trauma (a fourth degree tear) and live with long term morbidities which impact on my life to this day with symptoms including chronic perineal pain, dyspareunia, incontinence for flatus and at times faeces. I have undergone many diagnostic procedures and subsequent surgeries, to manage these symptoms, including a ganglion impar block in an attempt to block the transmission of pain to my perineum from the pudendal nerve pathway, and an anal sphincter reconstruction in an attempt to reconstruct a complete, functioning, anal sphincter muscle. Both were unsuccessful.
As a researcher who identifies with the group being researched, I bring an autoethnographic perspective to this study. Autoethnography, which arises from a combination of an autobiographical approach and ethnographic methodology, values the experiences of the researcher when they identify with the marginalised group under investigation, and considers these experiences a vital component of the data (Anderson, 2006; Ellis & Bochner, 2006). For the women who participated, being interviewed by a researcher who shared their experiences, influenced the dynamics of the research process as many of the women took the opportunity to ask questions during the interview.

Conducting this research as an autoethnographer presented multiple challenges to the way I understood my experiences, the experiences of others, and how I consequently now view myself as a woman and researcher. As a result I have undergone a transformation which I discuss more fully in this thesis and accompanying paper presented in Chapter Seven.

1.10 Thesis Structure

This thesis consists of eight chapters and contains four papers that have been accepted for publication in peer-reviewed journals (Chapters Three to Six), and one paper that is currently under review (Chapter Seven). These papers have been included within the thesis to present a logical flow of the stages of data collection and findings. The findings from a data linkage study examining trends and risk factors for SPT in NSW from 2000 – 2008, of which I am second author, is referred to throughout the thesis as supporting information, however this study was not part of the mixed methods research and is attached as an appendix (Appendix A) (Dahlen, Priddis, et al., 2013).
Chapter One provides an introduction and rationale for the study, and an overview of the incidence, risk factors and management of SPT. This chapter also presents the aims, objectives, the position of the researcher, and significance of this study.

Chapter Two presents the methodology used for this mixed methods transformative study, and details the methods used for each stage of the study. This chapter further outlines the framework, lens and perspectives used to guide, and view, the design of the research and analysis of the data. The ethical issues of this study are addressed.

Chapter Three presents the first publication, a meta-ethnographic synthesis (Stage 1) undertaken as the literature review for this study. This paper presents a synthesis of four qualitative papers exploring the experiences of women who sustained SPT, presents findings which revealed gaps in the literature that this study aimed to address. The major themes were: ‘I am broken and a failure’, ‘Dismissed, devalued and disregarded’, and ‘The practicalities of the unpredictable perineum’. The publication is titled: Women’s experiences following severe perineal trauma: a meta-ethnographic synthesis, published in Journal of Advanced Nursing in 2013.

Chapter Four presents the second publication titled: Risk of recurrence, subsequent mode of birth and morbidity for women who experienced severe perineal trauma in a first birth in New South Wales between 2000 – 2008: a population based data linkage study which presents the findings from the review of linkage data undertaken as Stage 2(a) of this study. The findings of this study report that primiparous women who sustain SPT are less likely to have a subsequent baby, more likely to have a related surgical procedure in the 12 months following the birth, and no more likely to have an caesarean section or sustain another SPT in a subsequent birth. This paper was published in BMC Pregnancy and Childbirth in 2013.
Chapter Five presents the third publication which reports on the findings of in-depth interviews conducted with 12 women (Stage 2(b)) who experienced SPT, and how these women described interactions and experiences with health professionals and services in NSW. The major themes were: ‘The abandoned mother’, ‘The fractured fairytale’ and ‘A completely different normal’. This publication titled: *Women’s experiences following severe perineal trauma: a qualitative study* was published in BMC Women’s Health in 2014.

Chapter Six presents the fourth publication which presents the findings of the discussions with the Clinical Midwifery Consultants of NSW (Stage 3). One overarching theme was identified: ‘A patchwork of policy and process’ with four subthemes. The paper is titled: ‘“A patchwork of services” – caring for women who sustain severe perineal trauma in New South Wales – from the perspective of women and midwives’. This paper was published in BMC Pregnancy and Childbirth in 2014.

Chapter Seven presents a paper outlining autoethnography as a methodological approach, and the personal challenges I faced as a researcher undertaking this method of ethnographic research. This paper is titled: *Autoethnography and severe perineal trauma – an unexpected journey from disembodiment to embodiment* and is currently under review.

Chapter Eight provides a discussion, which includes an integrated analysis of the four stages of this study, and compares the findings of this analysis with existing literature. The discussion highlights new knowledge with implications for midwifery practice, health service design and policy development when caring for women who sustain SPT.
1.11 Conclusion

This chapter has introduced the thesis, and presents the aims and objectives for this study. Further, an overview of the incidence and risk factors for SPT, associated morbidities, and research exploring prevention and management is presented. In addition, an overview of the experiences of women who sustain SPT was described, and an introduction to my story as a woman and researcher who has sustained a fourth degree perineal tear. The following chapter will detail the study design, research methodologies and methods used in this study.
Chapter Two: Methodology

2.1 Overview of methodology

This chapter outlines the aim and objectives for this study and describe mixed methods research and the transformative paradigm used to guide this study. An overview of autoethnographic methodologies is provided. Described are the stages of this study, including the recruitment process, demographics of participants, the methods of data collection and analysis used for each stage.

2.2 Aim and objectives

The aim of this mixed methods study is to understand the experiences of women who have sustained severe perineal trauma (3rd and 4th degree perineal tears) and associated morbidities, and to investigate health service provision across NSW, Sydney Australia.

This study has four objectives:

1) To examine the physical health, psychological, and social experiences of women who have sustained SPT.

2) To determine if there is any change in the incidence of SPT in NSW over the past eight years, and to determine the risk of recurrence, subsequent mode of birth and morbidity for women who experience SPT.

3) To describe the health services available for women who experience SPT in NSW.

4) To present integrated data focused on transformation to inform service design, delivery and best practice when caring for women who experience SPT.
2.3 Mixed methods research

This study is a mixed methods study underpinned by a transformative paradigm, incorporating both qualitative and quantitative methods for data collection to allow for comprehensive investigation of the research topic (Begley, 1996; N. K. Denzin, 1989; Taylor, Kermode, & Roberts, 2006). There are four stages of data collection that occur sequentially (Stages 1, 2a, 2b, and 3), with Stages 2a and 2b undertaken concurrently. Mixed methods research involves the collection and integration of both qualitative and quantitative data within one study to gain a better understanding of the topic under investigation (Ivankova, Creswell, & Stick, 2006; Tashakkori & Teddlie, 2003). This approach is becoming increasingly popular in health research fields, as it is suggested that qualitative or quantitative methods may not be sufficient on their own to address complex questions related to health and health services. The combination of both qualitative and quantitative methodological approaches draws on the strengths of each approach, and as a result can bring multi-level perspectives (J. Creswell, Klassen, Plano Clark, & Clegg Smith, 2010; Greene & Caracelli, 1997).

When undertaking mixed methods research, the use of an overarching perspective or paradigm is important to position the aim of the research and guide research methods. Historically, pragmatism has been the paradigm deemed most appropriate to use with mixed methods, as taking a pragmatic position affords greater importance to the research topic and question than the chosen methodologies or philosophical positions (Andrew & Halcomb, 2008; Gamble et al., 2005). However, mixed methods research can be interpreted using any theoretical framework or paradigm that is appropriate to the phenomenon under investigation (Giddings & Grant, 2006; Steen & Roberts, 2011). A transformative mixed methods research design is chosen when a transformative or emancipatory paradigm is selected to guide the research; a
transformative paradigmatic framework aims to create change for the groups under investigation (J. Creswell & Plano Clark, 2011; Mertens, 2003).

2.4 Transformative Research

Transformative research aims to identify and challenge social injustices experienced by marginalised groups. It is a way of developing a critical investigative research design to advocate for change through the research process (J. Creswell & Plano Clark, 2011; Steen & Roberts, 2011). Mertens (2009) suggests that such groups include feminists, indigenous peoples, ethnic minorities, people with disabilities, and those with varying sexual orientations (Mertens, 2009). The transformative paradigm arose from the emancipatory model, as researchers used research to achieve social transformation for marginalised groups and as “...an explicit goal for research to serve the ends of creating a more just and democratic society that permeates the entire research process, from the problem formulation to the drawing of conclusions and the use of results.” (Mertens, 2003, p. 159).

The design process of transformative research is developed sequentially to be both responsive and reflexive to issues identified from the initial findings and existing theory (Steen & Roberts, 2011). It is further influenced by the theoretical lens through which the research is viewed. In this study an interpretive feminist lens is used which allows for the exploration of gender related oppression and marginalization, and values the voice of the lived experience of women who experience SPT (Ackerly & True, 2010; Priddis, Schmied, & Dahlen, 2014). In a transformative paradigm participation of members of the group is valued, to ensure the findings of the research reflect the needs of the community. Further, when designing the methods and processes of data collection, consideration should be given to ensuring that the chosen design
and analysis process will result in transformation through social change (J. Creswell & Plano Clark, 2011; Mertens, 2009; Sweetman, Badiee, & Creswell, 2010).

In designing a mixed methods study consideration must be given to the sequence of implementing qualitative and quantitative methods, the priority to be given to the method of data collection, the stages of data integration and the theoretical perspective (Ellingson, 2006; Leder, 1990). Creswell and Plano Clark (2011) identify six major mixed methods research designs, including: convergent parallel, explanatory sequential, exploratory sequential, embedded, transformative, and multiphase (J. Creswell & Plano Clark, 2011). Creswell, Plano Clark, Gutmann & Hanson (2003) state that the purpose of sequential transformative mixed methods design “...is to employ the methods that will best serve the theoretical perspective of the researcher.” (Steen & Roberts, 2011, p.228).

**Sequential Transformative Design models** (Steen & Roberts, 2011, p. 225)

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QUALITATIVE → quantitative
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QUANTITATIVE → qualitative
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Qualitative research methodology is concerned with the exploration and study of human experience via observation, interview and/or focus groups (Nieswiadomy, 1998; Taylor et al., 2006). Braun and Clarke (2006) propose that the use of qualitative methodology enables the researcher to select: “…a method that works both to reflect reality and to unpick or unravel the surface of ‘reality’.” (Braun & Clarke, 2006, p.81). In this study the use of qualitative
methodological approaches allows for an understanding of the perspective of an individual woman who experiences SPT within NSW (Clair & Wasserman, 2007), which was informed by the perspective of the woman through in-depth individual interviews, and thematic findings of the meta-ethnographic synthesis. In addition, a qualitative design is used to guide data collection and analysis of the discussion group with the Clinical Midwifery Consultants of NSW.

Quantitative research is a systematic approach to gathering and statistically analysing empirical data sets to describe or test a pre-determined hypothesis, or answer a research question (Goldberg, 2002; Nieswiadomy, 1998). Information is analysed and reported in a numerical format. In this study the use of a quantitative methodological approach allowed for a statistical representation and overview of: the incidence of SPT across NSW from 2000 – 2008; incidence of in-patient readmission; and the impact of SPT on subsequent modes of birth. These data were identified through an analysis of linked data and this paper is presented in Chapter Five.

A mixed methods approach, using both qualitative and quantitative methods, best facilitates the identification of both discourses and causal factors in this complex area of postpartum morbidity, and the relation of these factors to the long term physiological and psychosocial outcomes for women who experience SPT and associated postpartum morbidities. These forms of data are collected sequentially (with Stages 2a and 2b collected concurrently), with each stage informing the other. The themes identified in the meta-synthesis are used to inform the questions asked during the interviews with women. The themes from the meta-ethnographic synthesis, the statistics from the linked data, and the data analysis from the interviews with women, assist in informing the design of the discussion group with the CMCs of NSW, and the design of the survey distributed during this discussion group. These findings are then integrated.
into the final analysis to ensure the research aim and objectives are achieved, and to inform transformation in practice (Ellingson, 2006; Leder, 1990).

A transformative framework is selected to guide the design of this mixed methods study with the purpose of developing an in-depth understanding of the experiences of women who sustained SPT. To achieve this it is important that multiple methodological approaches are used to hear the words of the women as they describe their experiences, and to understand this by examining the incidence and consequences of SPT by reviewing large datasets and analysing the outcomes for women in NSW. Further, these findings are also framed and informed by my personal experiences as an autoethnographer and member of the marginalised group. By obtaining an overview of service provision for women who sustained SPT in NSW, this knowledge may be used to inform future service design for women.

2.5 Autoethnography

When a transformative framework is used, the researcher may be a member of the marginalized group as a result of illness, circumstance or from birth. For researchers who self-identify with the marginalised group, a critical self-reflective stance is brought to the design, analysis and writing of the research itself, this is known as “autoethnography” (Danaher, Schirator, & Webb, 2000). I incorporate an autoethnographic approach into this study based on my own experience of a 4th degree tear following the birth of my second baby resulting in ongoing morbidities that have had a significant impact on my physical and emotional wellbeing. When incorporated into a research project, the experiences of the autoethnographer are considered vital to the data in understanding the marginalised group of which they are a part (Anderson, 2006). A multivocal narrative approach (Ellis, 1997; Tomaselli, Dyll-Myklebust, & van Grootheest, 2013) is taken in presenting the findings which incorporate the words of both myself, as an autoethnographer,
and the twelve women who are interviewed as a component of the study who had sustained SPT as presented in Chapter Seven.

The growth of autoethnography as a methodological approach conflicts with traditional perspectives that value objectivity, validity and reliability in the design and analysis of data. As a result there are multiple definitions and presentations of this methodological approach (Ellis & Bochner, 2006; Muncey, 2010). Evolving from the work of ethnography, whereby the researcher explores meaning behind behaviour and interactions in a specific cultural group within a natural context, autoethnographers identify their position within the cultural group being researched and weave their personal experience into the analysis and interpretation of the collected data, focusing specifically on reflexivity and self-consciousness (Anderson, 2006; J. W. Creswell, 2007; Ellis & Bochner, 2006; Hammersley & Atkinson, 2007; Jones, Adams, & Ellis, 2013). When incorporated into a research project, the experiences of the autoethnographer are considered vital to the data in understanding the marginalised group of which they are a part (Anderson, 2006).

The conduct of autoethnographic research requires a higher level of participation and self-reflection than is required in qualitative research projects (Ellis, 1999). While the use of an autoethnography perspective is not suitable for inclusion for each stage of this mixed methods study, it is impossible to separate the experience of the researcher from the review and analysis of the data. Further, the researcher, being able to identify with the marginalized group under investigation through their own knowledge of the culture, language and experiences, means that they are more readily accepted by those being researched (Leslie & McAllister, 2002; Simmons, 2007). However, knowledge as an insider can be perceived as both an advantage and disadvantage, as stated by Kanuha (2000, p. 444):
“For each of the ways that being an insider researcher enhances the depth and breadth of understanding a population that may not be accessible to a non-native scientist, questions about objectivity, reflexivity and authenticity of a research project are raised because perhaps one knows too much or is too close to the project and may be too similar to those being studied.”

Commencing this research project, the intention was to weave the autoethnographic perspective throughout each of the qualitative papers produced as a result of this research. Throughout the entire research process I documented my feelings and thoughts through a personal journal and email exchanges with my principle doctoral supervisor. This was as a result of continual self-reflection, as each emotion or thought process arose I acknowledged it and reflected through the written word. However, due to the word limitations set by each journal to which the individual papers were submitted, including all the data required for an autoethnographic perspective, was not possible. Therefore I decided to write a paper on my experiences as an autoethnographer, which is currently under review and presented in Chapter Seven.

2.6 Methodology and Methods

There are four stages of data collection in this study; three stages use a qualitative methodological approach, one stage uses a quantitative methodological approach. Data are collected both sequentially and concurrently. Stage 1 informs the design of Stage 2; Stages 2(a) and 2(b) are conducted concurrently. Stages 1, 2(a) and 2(b) all inform the design of Stage 3.
2.7 Stages of the study

Stage 1

Aim:

The aim of the meta-ethnographic synthesis is to review and synthesise qualitative literature examining the experiences of women who sustain SPT during vaginal birth.

A comprehensive literature search identified a paucity of research into the experiences of women who sustain SPT due to childbirth, therefore a meta-synthesis of qualitative research was undertaken. Using the analytic strategies and theme synthesis techniques of reciprocal translation and refutational investigation as described by Noblit and Hare (1998), the meta-
synthesis technique, which reported on women’s experiences following SPT, was seen as an opportunity for qualitative research to be compared and analysed, thus allowing the researcher to create new interpretations of thematic data (Noblit & Hare, 1988; Ring, Ritchie, Mandava, & Jepson, 2011). The findings of the meta-ethnographic synthesis are reported in detail in Chapter Three.

Method:

Databases searched included CINAHL, PubMed, Scopus, MD Consult and SocIndex with Full Text. The search was limited to January 1996 to June 2011 as current literature was sought. Search terms were limited to English and full text journal articles only. Search terms used Medical Subject Headings (MeSH terms) included, ‘perineal trauma’, ‘perineal injury’, ‘third and fourth degree tears’, ‘obstetric trauma’, ‘women’s experience’, ‘health services’ ‘qualitative research’, ‘quality of life’, AND/OR ‘collaborative care’. Studies included were qualitative or mixed methods research with a qualitative component, using any related methodological approach.

A total of 478 papers were identified through the search. Titles and abstracts were read and papers that reported quantitative studies, opinion papers, and medical reports were excluded. Further exclusions included articles related to paediatrics, orthopaedics, geriatrics, and pelvic studies unrelated to childbirth. Eight relevant research papers were identified. Reference lists of these research papers were searched by hand for additional relevant research papers not identified in the initial literature search however no additional papers were identified. These eight research papers were read in full and excluded if open-ended data obtained by postal surveys was not in-depth, or the experiences of women with perineal trauma was not the main focus. This reduced the relevant research papers to four (Chapter Three). To assist with the
evaluation of the quality of the papers selected for inclusion, the Critical Appraisal Skills Programme (CASP) tool for quality assessment of qualitative research was applied (Appendix B) (Shapiro, Setterlund, & Cragg, 2003). All papers included in the review met quality criteria, and all four papers were read in full by two authors to ensure relevance.

**Analysis:**

A seven phase approach designed by Noblit and Hare (1988) was applied to the synthesis of the qualitative articles, outlined in the publication presented in Chapter Three. Using the seven phase approach, reciprocal translation and refutational investigation, five initial themes were identified during the initial synthesis undertaken by the first author. This initial process involved the design of a table which listed each major thematic finding of the four included papers. The first author then worked through these themes to identify any similar (reciprocal translation) or contrasting (refutational investigation) themes or metaphors across the articles (Noblit & Hare, 1988). No refutational findings were identified between the four studies. From this initial process, five initial overarching themes were then identified by the first author. These initial themes were further examined individually by the co-authors and, following discussion it was agreed that, of the five original themes, three described similar findings and were therefore combined (Steen & Roberts, 2011). The three remaining themes identified were: ‘I am broken and a failure’, ‘Dismissed, devalued and disregarded’, and ‘The practicalities of the unpredictable perineum’ (Chapter Three).
Stage 2a

Aim:
To determine the risk of recurrence, subsequent mode of birth, and morbidity for women who sustain SPT during their first birth in NSW over the past eight years.

Design: A study using linked data was undertaken. All singleton births recorded in the NSW Midwives Data Collection between 2000 – 2008 (n=510,006) were linked to Admitted Patient Data and analysed. Determination of morbidity as a result of SPT was based upon readmission to hospital following birth within a 12 month time period for a surgical procedure falling within four categories: 1. Vaginal repair, 2. Fistula repair, 3. Faecal and urinary incontinence repair, and 4. Rectal/anal repair.

Sample: Data reporting births from July 1st 2000 until June 30th 2008 of all singleton births was provided by the NSW Department of Health as recorded in the NSW Midwives Data Collection (MDC). The sample included a total of 510,006 singleton vaginal births.

Data on all subsequent hospital admissions was provided by census data collection, the Admitted Patient Data Collection (APDC). The clinical data component of the APDC utilises the International Classification of Diseases – Australian modification (ICD-10-AM). Probabilistic linkage of the two datasets was undertaken by the Centre for Health Record Linkage.

Data analysis:
Descriptive analyses of short and long term morbidity associated with all types of perineal trauma were produced utilising SPSS v.19 (IBM). Frequency distributions were used to classify the population and descriptive statistics calculated for the morbidity outcomes. Relative risk
was calculated between factors and events and Odds Ratios (OR) are reported for rare outcomes. Due to the number of associations examined, the level of statistical significance was set at <0.001. The findings from Stage 2b are presented in detail in Chapter Five.

**Stage 2(b)**

**Aim:**

The aim of the interviews was to understand the individual experiences of SPT from the perspective of the women, with a specific focus on the care they received from health services, and from health professionals during the birth and suturing process, in the immediate and long term postpartum periods.

**Design:**

Face to face in-depth interviews were undertaken with 12 women who had sustained SPT.

**Participant demographics and recruitment:**

Potential participants contacted the first author in response to a recruitment flyer (Appendix C) distributed from October 2011 – April 2012 via social media (Facebook) and word of mouth through midwifery colleagues. In addition, snowball sampling was used as the participants suggested other women who may also be suitable to participate in the study. Fourteen women made contact via email in response to the flyer, two of these women were excluded as the perineal trauma they had sustained was not classified as severe and therefore they did not meet the criteria.
Following initial contact, all women were provided with participant information sheets (Appendix D) and a consent form (Appendix E) by return email, this provided the participants with an opportunity to read through the information provided. Twelve women were recruited to, and participated in, this study. The demographics of the participants are detailed in Chapter Four.

Data Collection:

The interviews were semi-structured, using open ended questions, however, a conversational style was frequently adopted with the women often leading the interviews. Some of the questions used to guide the conversation included: “With which baby did you experience a third or fourth degree perineal tear? Can you tell me about your experience?”, “What symptoms did you experience that you feel were due to the tear?”, and “How did these symptoms affect your ability to care for your baby?” (Appendix G). These questions were informed by the findings from Stage 1 of the study. During the interview process, it was explained to all participants that I had sustained SPT (a fourth degree tear) and had experienced long term morbidities. As an “insider” this transparency enabled the ability for me to develop rapid rapport and establish relationships with the participants.

Data Analysis:

Data were analysed using thematic analysis, a process which enables identification, analysis and interpretation of themes within data. Through an iterative process, data is broken into categories, then subcategories, to assist with the identification of themes (Braun & Clarke, 2006; Liamputtong, 2009). Through the process of thematic analysis, the first author individually reads each interview transcript to identify patterns of words or statements that
related to the aim of the study and these are placed in broad categories. These results were then discussed with research supervisors to ensure the validity of the findings (Braun & Clarke, 2006; Liamputtong, 2009). The broad categories were then analysed in detail to identify subthemes which represent the patterns within the broad categories. Overarching themes were then developed to accurately reflect the findings within the data (Polit & Hungler, 1997). A theme represents an important concept, which is repetitively within the data and which relates directly to the research question (Braun & Clarke, 2006). Once the main themes were identified, subthemes were developed to accurately reflect and explore the findings (Polit & Hungler, 1997).

To become immersed in the data, I listened to the recordings of the interviews and transcribed eight of them, the remaining four interview recordings were transcribed by a professional transcription company. Each transcript was read multiple times to identify any gaps and/or errors in the transcription process. During this time key sentences and concepts were underlined, and notations placed in the side margins to record my initial thoughts. These twelve transcripts were then uploaded into a data management software program NVivo 10. This software assists with the organisation of complex data sets and management of large amounts of data (QSR International Pty Ltd, 2012). Once entered into NVivo 10, the initial key sentences and concepts that were underlined on the paper versions of the transcripts were used as a guide to further group data and develop key subthemes and then main themes.

The findings from Stage 2b, including the main themes, sub themes and the discussion, are presented in Chapter Five.
Stage 3

Aim:

To gain an understanding of the health services available for women who experience SPT in NSW from the perspective of senior midwives and women.

Design:

A discussion group with the CMCs of NSW.

Participants:

Fourteen CMCs participated in this study, and all were experienced midwives currently practising in NSW. In their roles as consultants, CMCs are responsible for writing policy, supporting best practice, and providing midwifery leadership across the state. They are ideally positioned within their roles to have a comprehensive view of how the service works and where its strengths and weaknesses lie. The Clinical Midwifery Consultant role evolved from the Clinical Nurse Consultant role, and was established with the identification of midwifery as a separate profession (NSW Department of Health, 2007). To be considered for the Clinical Nurse Consultant role a minimum of 5 years full time post graduate experience is essential. Additional postgraduate qualifications may be required by the employer (NSW Department of Health, 2007).

The CMCs who participated in the group discussion represented both regional and rural local health districts (LHD), including individual hospitals and maternity services across NSW. At the time of this study there were 16 LHD’s in NSW, all but one LHD was represented in the
discussion group. All CMC’s who participated were female with an average age of 52 years
(Chapter Six).

Data collection:

The participants were provided with printed copies of the information sheet (Appendix H),
consent sheet (Appendix I) and demographics sheet (Appendix J), and were given an
opportunity to ask questions based upon this information prior to the commencement of the
discussion group. The participants were advised that the discussion group was to be recorded
with a digital recording device and that recording could be ceased at any time without penalty.
Those CMCs not able to participate were given an opportunity to leave prior to the discussion
commencing. The participants were advised that all data would be de-identified during the
transcription process to protect identities.

Due to the limited time allocated to the discussion group (one hour) and the number of CMCs
in attendance, a survey (Appendix K) was distributed to them prior to the commencement of
the discussion group. The purpose of this survey was to enable a more comprehensive
understanding of the services provided in NSW. The discussion group was semi structured in
design using open ended questions (Appendix L). The questions for both the discussion group
and the survey were designed in response to the overarching themes that were identified from
the meta-ethnographic synthesis and the interviews with women. The discussion group was
recorded using a digital voice recorder and later transcribed verbatim and hand coded using
thematic analysis to identify key themes and points of discussion.

Both the interviews with the women and the discussion group were recorded using a digital
recording device. Following each interview and the discussion group, I completed a reflective
journal to capture whatever the digital recording device was unable to record, such as the expressions, tone and body language used by each participant, along with a personal reflection looking at how each interview impacted upon myself as an autoethnographer.

**Data Analysis**

An integrative approach was used in reporting the findings, which involved comparing and analysing the findings from three sets of data – the survey results, discussion group transcripts, and the interviews with women (Bazeley & Kemp, 2011). Integration was undertaken with the aim of facilitating a greater understanding of the topic under investigation (Bazeley, 2009; Bazeley & Kemp, 2011). Initially the analysis of both datasets from the CMC discussion group and the interviews with women were conducted separately using thematic analysis described above.

The survey responses were recorded and compared with the themes identified from the CMC discussion group, the similarities and disparities were noted. The priority data set represented the themes identified following the discussion group with the CMCs. Data from the in-depth interviews with women involved in Stage 2a, but not published in the paper presented in Chapter Four, were used to provide added depth to the main themes.

During comparative analysis the major themes and subthemes, arising from the two separate datasets, were analysed and compared to determine similarities and differences. The themes that overlapped or were common to both data sets were then integrated to undertake a second level of analysis. Through this process common themes were identified which enabled an understanding of how health services in NSW care for women who sustain SPT from the perspective of women and CMC’s.
The findings from Stage 3, including the main themes, sub themes and the discussion, are presented in Chapter Six.

2.8 Integration

When undertaking mixed methods research, the aim of collecting and integrating both the qualitative and quantitative data is to facilitate a greater understanding of the topic under investigation (Bazeley, 2009; Bazeley & Kemp, 2011; Tashakkori & Teddlie, 2003). During the stages of this study, integration was achieved by using the findings from each stage to inform the data collection and analysis of each subsequent stage. In addition, the aim of integrating the findings from this study was to determine how services that provide care for women who have sustained SPT could be improved; this information will assist in informing recommendations for future practice and service provision. The table overleaf demonstrates the points of integration that occurred throughout the duration of the study.
Figure Two: Stages of data collection and points of integration

1. Stage 1: Meta-ethnographic synthesis
   - Synthesis of four qualitative papers identified by literature review
   - Seven phase approach (Noblit and Hara, 1988) reciprocal translation and refutational investigation. Three themes identified
   - Themes identified used to inform questions in Stages 2(b) and 3.

   - Data collected from Midwives Data Collection and Admitted Patient Data Collection
   - Descriptive analysis using of data using SPSS v.19
   - Findings combined with themes identified from Stages 1 and 2(b) to inform questions for Stage 3

3. Stage 2 (B): Interviews with 12 women who sustained SPT
   - Interviews recorded and transcribed verbatim. Data exported into NVIVO 10
   - Thematic analysis of data. Three main themes identified
   - Themes identified from Stage 2(b) used with data from Stage 2(a) to inform questions for Stage 3

4. Stage 3: CMC discussion group and survey
   - Discussion recorded and transcribed verbatim. Survey responses collated.
   - Integrative approach comparing and analyzing findings from discussion group, survey and interviews with women
   - Final integration of data from all Stages to develop recommendations for practice
2.9 Ethical Considerations

All research brings about multiple ethical considerations, with ethical evaluation of a research project and protection of all human participants a moral requirement (Aita & Richer, 2005). The principles of integrity, respect for persons, beneficence and justice, require consideration throughout the entire research process, concepts first explored in the Nuremberg Code of 1947 then further defined by the Belmont Report of 1979 (Aita & Richer, 2005; NHMRC, 2007). This is of particular importance when conducting research with vulnerable, marginalised groups such as women who have sustained SPT. Ethics approval was obtained through the University of Western (UWS) Sydney’s Board of Ethics (Ethics Approval Protocol Number: H9298) (Appendix M).

**Autonomy**

The concept of autonomy refers to the right of the individual to make an informed decision without coercion (Charter, 2011; Silva, 2012). In this study all women who met the eligibility criteria and were over the age of 18 were invited to participate. Each woman was sent an information sheet which outlined the aim of the study, described the process of the study, and outlined any potential risks or benefits (Appendix D). The women and CMCs who participated in this study were advised that they were free to withdraw at any time and that participation was voluntary.

**Informed consent**

Informed consent requires all potential participants of a research project to be provided with full information about the project, thus enabling the participant to provide fully informed consent for voluntary participation, or to decline, without coercion or consequence (Aita &
Richer, 2005; Crow, Wiles, Heath & Charles, 2006; NHMRC, 2007). To ensure informed consent, participation in the interviews, discussion group and survey and was self-determined in response to the distribution of the information sheets by email that provided full disclosure of their role (Appendices D and G). Participants were given the contact details of the researcher to ask any questions prior to giving consent. Participants were then asked to read and sign the consent form prior to the commencement of the interviews and the discussion group if they agreed to participate.

When conducting research using an autoethnographic perspective, while the focus is on the sharing of the personal stories and experiences of the researcher, there may be others who have participated in, or played major roles, in the experience and who therefore become part of the story being told (Bochner, 2002; Tullis, 2013). Being mindful of this, in this research no names of my family or care providers were used, or locations in which I birthed or received follow up care were identified. In the sharing of my story I made limited reference to others outside of myself and my immediate family, with the focus on my experiences and feelings.

**Confidentiality**

Considerations of confidentiality were considered critical due to the sensitive nature of the topic under investigation. Further, as many of the women who participated in this study had not disclosed many of their symptoms and ongoing morbidities to their significant others, family and friends, maintaining confidentiality was of the utmost importance to the women prior to recruitment and during the interview process. All participants in this study were assured of confidentiality, and advised that they were able to request that the digital recordings cease immediately, or withdraw from participation at any time without penalty (NHMRC, 2007). This information was within an information sheet distributed to the participants prior to the
interviews and discussion group. To maintain confidentiality, once digital recordings were accurately transcribed the recordings were deleted. Further, once transcriptions were completed, they were de-identified and names were replaced with numbers (1 – 12), and then pseudonyms, for ease of reference prior to analysis.

The participants were offered support and counselling if required, as described in the following section. Participants were advised that data was de-identified and aggregated to ensure that individual participants are unable to be identified (NHMRC, 1998).

**Beneficence**

During the conduct of a research project, it is the moral responsibility of the researcher to minimise the risk of discomfort or harm to the participants, guided by the principle of beneficence (Aita & Richer, 2005; NHMRC, 2007). The wellbeing of the participants take precedence over data collection at all times, in order to comply the ethical consideration of respect for persons (NHMRC, 2007; Thompson, Melia & Boyd, 2000).

Due to the sensitive nature of the topic under investigation the researcher was mindful that issues, such as stigma and the cultural perception of the “normal” postnatal body, may prevent some women from disclosing their experiences in full. It was also understood that due to the exploratory nature of individual in-depth interviews, the women may disclose issues they have not previously discussed with others. Although women in the postnatal period are not classified as a “vulnerable population”, it was recognised that women early in the postnatal period (12 months following the birth of their baby) may be experiencing increased emotional intensity as they transition to motherhood (Aita & Richer, 2005; NHMRC, 2007). To address this, women were informed and reassured that if at any time during the interview they experienced
distress, they may request the interview to cease without penalty (Thorpe & Anderson, 2006). The women were encouraged to seek support following the interview if required; this information was provided in the information sheet and consent form, with a list of service providers. If a participant became distressed, immediate counselling was provided.

All participants were offered support and counselling if required, and were advised of support services prior to and following data collection. Participants were advised that to reduce the risk of causing harm, data was aggregated to ensure that individual participants cannot be identified, as specified under Section 95 of the Privacy Act 1988 (NHMRC, 1998).

**Risk versus benefit**

Despite no immediate benefits to participants, the women who participated may have had an opportunity to develop a further understanding of the physiology of SPT, related symptoms and ongoing morbidities as a result of the exchange of information that occurred during the interview process. Some of the women asked questions to the researcher about strategies for reducing the fear of perineal pain during sexual intercourse. The strategies appeared to be beneficial as two of the women who independently emailed me following the interview advised that they had successfully engaged in sexual intercourse and had found the experience positive.

Following the discussion group and survey, the CMCs who participated were given the opportunity to reflect on the current health system structure in NSW providing care for women who sustain SPT.

As an autoethnographer not only did I have to be mindful to apply ethical considerations to the participants of the study, but also of the need to develop a way to protect myself and understand my own risk of harm (Chang, 2008; Tolich, 2010). Through the process of sharing an
experience or a story an autoethnographer may experience a sense of peace or closure. However when the experiences that are shared are of a sensitive or confronting nature, the researcher may experience a sense of vulnerability and distress (Ellis, Adams, & Bochner, 2010; Tullis, 2013). This experience has been explored in detail in the paper presented in Chapter Seven.

**Rigor**

Rigor in the context of research reflects the quality of the research process and is determined through systematic research design and data collection, interpretation, and communication of results (Pope & Mays, 2006). To determine rigor in qualitative research findings must be credible, transferable, dependable and confirmable (Guba & Lincoln, 1989).

Credibility is determined when the perspective of the participants is reflected in the findings (Beanland, Schneider, LoBiondo-Wood, & Haber, 1999). In this study, the participants were invited to review the papers produced from this research prior to publication (Hall & Stevens, 1991). Participant involvement throughout the entire research process is also considered important when using a transformative framework (Mertens, 2009). Through the process of autoethnography and reflexivity, the contribution of my personal story to the collected data provides transparency and additional insight into the perspectives.

Transferability refers to the ability to transfer the findings of the study from one context to another (Saini & Shlonsky, 2012). In this study, transferability was achieved through the clear description of the various data collection methods, analysis process, and the participants of this study (Chapters Three to Seven). The correlation of the findings of this study with existing literature that reports women’s experiences following SPT, supports the transferability of findings to another context or setting (Grbich, 2007; Saini & Shlonsky, 2012). Transferability
specific to the discussion group held with the CMCs of NSW has been explored in the peer reviewed publication presented in Chapter Six.

Dependability of this research was achieved through verification of transcribed data and the discussion of identified themes with the research supervisors, therefore promoting dependability of analysis through the use of multiple viewpoints (Long & Johnson, 2000). The dependability of the research is also reliant upon the quality of the data (Litva & Jacoby, 2007). Four of the interviews were transcribed by the researcher, the remaining eight interviews and the discussion group were recorded with the use of a digital voice recorder and transcribed through a transcription company - Pacific Solutions.

**Reflexivity**

Analytic reflexivity requires the researcher to have an awareness of their place within the research and the potential impact this may have upon the interaction with study participants and interpreting the data (Anderson, 2006). This is of particular importance when the researcher identifies with the group being researched, such as in autoethnography. The use of analytic reflexivity ensures objectivity and authenticity throughout the research process.

**2.10 Conclusion**

This chapter has presented an overview of the aim and objectives of this study, the theoretical framework and methodological approaches. Data collection and analysis processes have been described in detail. Ethical considerations for both mixed methods and autoethnographic research have been discussed. The following chapter presents the first publication from the
findings of this study titled: “Women’s experiences following severe perineal trauma: a meta-ethnographic synthesis.”
Chapter Three: Women’s experiences following severe perineal trauma: a meta-ethnographic synthesis.

3.1 Publication relevance to thesis


For Stage 1 of this study, a meta-ethnographic synthesis was conducted to review and synthesise qualitative literature examining the experiences for women who have sustained SPT. This paper presents a meta-ethnographic synthesis of four qualitative papers that were identified following a literature review. Three major themes were identified: ‘I am broken and a failure’, ‘Dismissed, devalued and disregarded’, and ‘The practicalities of the unpredictable perineum’. The findings suggested that SPT appeared to affect the woman’s physical and psychological wellbeing, and for some women this resulted in social isolation and marginalisation due to ongoing symptoms related to SPT.
REVIEW PAPER

Women’s experiences following severe perineal trauma: a meta-ethnographic synthesis

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Abstract

Aims. This article presents a meta-ethnographic synthesis of studies on women’s experiences of sustaining a third or fourth degree tear during childbirth.

Background. It has been reported that for women who sustain third or fourth degree perineal tears (severe perineal trauma) some may experience extensive physical and psychological outcomes.

Design. A meta-ethnographic synthesis.

Data sources. The CINAHL, PubMed, Scopus, MD Consult, and SocIndex with Full Text databases were searched for the period January 1996 June 2011. Out of 478 papers retrieved four met the review aim.

Review methods. A meta-ethnographic synthesis approach was undertaken using analytic strategies and theme synthesis techniques of reciprocal translation and refutational investigation. Quality appraisal was undertaken using the Critical Appraisal Skills Programme (CASP) tool.

Findings. Four qualitative papers were included, with three major themes identified: ‘I am broken and a failure’, ‘Dismissed, devalued and disregarded’, and ‘The practicalities of the unpredictable perineum’.

Conclusion. There is evidence to suggest that for women who experience severe perineal trauma during childbirth the physical and psychological outcomes can be complex, with some women experiencing social isolation and marginalization due to their ongoing symptomatology. Severe perineal trauma appeared to affect not only physiological and psychological well-being but also altered the women’s understanding of their identity as sexual beings. Health professionals should be mindful of the language that they use and their actions during suturing and the postpartum period to avoid causing unnecessary distress.

Keywords: meta-ethnography, qualitative study, quality of life, severe perineal trauma, third and fourth degree tears, women’s experiences
Introduction

Severe trauma (third and fourth degree tears) to the perineum, the area between the anus and the vagina, can occur spontaneously or as a result of obstetric intervention during vaginal birth (Dahlen et al. 2007, Fernando et al. 2010). Severe perineal trauma during childbirth is classified as a third degree tear, which involves injury to the perineum involving the anal sphincter complex; or a fourth degree tear, which involves injury to the perineum involving the external, internal, and epithelium of the anal sphincter (RCOG 2007) Table 1. Although the exact figures for the incidence of severe perineal trauma are unclear, current Australian figures indicate that this rate ranges from 1.5 - 2.3%; on an international scale, the incidence is reported to range from between 0.5 - 7% (Kettle & Tohill 2008, Laws et al. 2010).

The extent of complications experienced by a woman following perineal trauma is reported to be directly related to the severity of the trauma and appropriate repair (Kettle & Tohill 2008). Following severe perineal trauma, some women remain asymptomatic, whilst other women may experience any or all of the following symptoms, including: stress and/or urge urinary incontinence, flatus, and faecal incontinence, haemorrhoids, dyspareunia, and risks of the development of additional morbidities such as vesico-vaginal fistulas and pelvic organ prolapse (Wall 1999, Pauls et al. 2007, Bagade & Mackenzie 2010, Rathfisch et al. 2010, Tin et al. 2010). The exact incidence of short- and long-term symptoms as a result of severe perineal trauma is unknown.

Research has highlighted the many challenges that women face in the transition to motherhood (Fowles 1998, Mercer 2004), when a woman experiences an unexpected morbidity due to childbirth, the postnatal period becomes increasingly stressful and complex, and women may become socially isolated as a result (Brown & Lumley 1998, Mercer 2004, Lee & Gramotnev 2007). According to the literature the psychological impact following severe perineal trauma, particularly for women who experience multiple symptomatology long term, is reported as extensive and complex (Fowles 1998, Fox & Ward 2006, Browning et al. 2007). With an increasing global birth rate and rising intervention in birth, the incidence of severe perineal trauma as a result of vaginal birth is reported to be increasing on an international scale (Kettle & Tohill 2008, New Health 2009). It is unclear, however, whether this is due to improved recognition and reporting or an actual rise. Severe perineal trauma and related postpartum morbidity is identified as a reason for litigation in maternity care, and consequently is associated with increased national healthcare costs to support women with ongoing morbidity and related symptomatology (Kettle 2005, Henderson and Bick 2005).

The review

Aim

Severe perineal trauma is reported to affect a small percentage of the childbearing population on an international scale, however, the impact of this can result in extensive and complex long-term physical and psychological morbidities. Therefore, the aim of this meta-ethnographic synthesis was to describe the physiological and psychological experiences of women who have experienced severe perineal trauma so as to inform the practice of health professionals specializing in the care of childbearing women, particularly during the postnatal period.

Design

This meta-ethnographic synthesis was undertaken using the analytic strategies and theme synthesis techniques of reciprocal translation and evaluative investigation as described by Noblit and Hare (Noblit & Hare 1988). This meta-ethnographic synthesis was seen as an opportunity for qualitative research to be compared and analysed, allowing the researcher to create new interpretations and understanding of thematic data (Noblit & Hare 1988, Campbell et al. 2011, King et al. 2011). Noblit and Hare (1988) describe meta-ethnographic synthesis as ‘the synthesis of interpretative research’ which enables the development of new insights into a phenomenon (Noblit & Hare 1988). This is supported

<table>
<thead>
<tr>
<th>Degree</th>
<th>Perineal trauma</th>
</tr>
</thead>
<tbody>
<tr>
<td>First</td>
<td>Injury to the skin only</td>
</tr>
<tr>
<td>Second</td>
<td>Injury to the perineum involving perineal muscles but not involving the anal sphincter</td>
</tr>
<tr>
<td>Third</td>
<td>Injury to the perineum involving the anal sphincter complex. This is further classified into 3a] Less than 50% of the external anal sphincter (EAS) torn 3b] Greater than 50% of the external anal sphincter torn 3c] External anal sphincter and internal anal sphincter (IAS) torn</td>
</tr>
<tr>
<td>Fourth</td>
<td>Injury to perineum involving the anal sphincter complex (external and internal) and anal epithelium</td>
</tr>
</tbody>
</table>

(RCOG 2007)
by Finfgeld (1999) who states that the aim of a meta-ethnography ‘...is to produce a new and integrative interpretation of findings that is more substantive than those resulting for individual investigations’ (Finfgeld 1999, p. 894).

Noblin and Hare (1988) propose a seven phase approach to the synthesis of qualitative articles, describing this as a process which evolves and repeats throughout the synthesis itself (Noblin & Hare 1988). The seven phases include: identifying an interest, deciding what is relevant to the matter of interest, reading the related studies, deciding how the chosen studies are related, translating the studies in relation to the other studies, synthesizing the translations, and finally presenting the synthesis in a format appropriate for an audience (Noblin & Hare 1988). These seven phases have been incorporated in this meta-ethnographic synthesis (Noblin & Hare 1988).

Search methods

Databases searched included CINAHFL, PubMed, Scopus, MD Consult, and Socindex with Full Text. The search was limited to January 1996 June 2011 as current literature was sought. Search terms were limited to English and full text journal articles only. Search terms using Medical Subject Headings (MeSH terms) included, ‘perineal trauma’, ‘perineal injury’, ‘third and fourth degree tears’, ‘obstetric trauma’, ‘women’s experience’, ‘health services’ ‘qualitative research’, ‘quality of life’, AND/OR ‘collaborative care’. Studies to be included were to be qualitative or mixed methods research with a qualitative component, using any related methodological approach.

Search outcome

A total of 478 papers were identified through the search. Titles and abstracts were read and papers that reported quantitative studies, opinion papers, and medical reports were excluded. Further exclusions included articles related to paediatrics, orthopaedics, geriatrics and pelvic studies unrelated to childbirth. Eight relevant research papers were identified. Reference lists of these research papers were searched by hand for additional relevant research papers not identified in the initial literature search, however, no additional papers were identified. These eight research papers were read in full and excluded if open-ended data obtained by postal surveys were not in depth, or the experiences of women with perineal trauma were not the main focus. This reduced the relevant research papers to four (Figure 1). Papers that reported findings based on postal questionnaires have been included in the discussion section. Following

Figure 1 Flowchart of search strategy.
### Table 2 Qualitative papers included in the meta-ethnographic synthesis.

<table>
<thead>
<tr>
<th>Author/Location</th>
<th>Methodology</th>
<th>Sample</th>
<th>Themes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Herron-Marx et al. (2007), Birmingham, UK</td>
<td>Retrospective Q Methodology through the use of interviews (20) and a postal response grid (14)</td>
<td>12–18 months postnatal. Self identified from previous research. 20 women participated in part one (interviews); 14 of the initial 20 participated in part 2 (postal response grid). 1 – intact; 1 – cesaean; 4 – episiotomy; 7 – 2nd degree; 1 – 3rd degree</td>
<td>1. Morbidity of minor inconvenience. 2. Insufficient support and services 3. The ‘humiliation’ of perineal morbidity 4. Normalizing perineal morbidity</td>
</tr>
<tr>
<td>Williams et al. (2005), Leicester, UK</td>
<td>Grounded theory analysis using focus groups (2)</td>
<td>Purposive sampling women approached attending a specialist perinatal clinic. 10 participants, all Caucasian. All participants had experienced a third degree tear</td>
<td>1. Apprehension about consequences of the injury in terms of consequence 2. Body image and sexual functioning 3. Anxiety about and lack of involvement in planning for future pregnancies 4. Poor information exchange and communication 5. Poor emotional support from professionals and family members 6. Physical and emotional impact 7. Unresolved anxieties in partners</td>
</tr>
<tr>
<td>Salmon (1999), South Wales, UK</td>
<td>A feminist analysis using in-depth unstructured interviews</td>
<td>Snowball sampling, 6 participants. All white British, aged 25–40. All worked in women health care professions. Degree of perineal trauma not specified</td>
<td>Three main themes: 1. The experiences of interpersonal relationships during suturing 2. Experiences of social support and interpersonal relationships whilst healing 3. Feelings associated with coming to terms with perineal trauma Subtheme: Women’s health as marginal: expressing pain as an example of feeling unheard First time experiences</td>
</tr>
</tbody>
</table>

New South Wales, Australia. All studies used various forms of qualitative methodology: retrospective Q methodology, phenomenology, grounded theory, and feminist analysis.

### Data abstraction and synthesis

Using the methods of reciprocal translation and refutational investigation, five initial themes were identified during the initial synthesis undertaken by the first author. This initial process involved the design of a table which listed each major thematic finding of the four included papers. The first author then worked through these themes to identify any similar (reciprocal translation) or contrasting (refutational investigation) themes or metaphors across the articles (Noblit & Hare 1988). No refutational findings were identified between the four studies. From this initial process, five initial overarching themes were then identified by the first author. These initial themes were further examined.
individually by the co-authors and following discussion it was agreed that of the five original themes, three of the themes described similar findings and were therefore combined (Steen & Roberts 2011). The three remaining themes were developed and are presented below with the inclusion of direct quotations from the women who participated in the included studies (Table 3) (Noblit & Hare 1988). The use of direct quotes has been incorporated into this meta-ethnographic synthesis to ensure the context in which the quote was used in the original paper was interpreted correctly.

Findings

'I am broken and a failure'

The theme of 'I am broken and a failure' encompasses the complex depth of emotions experienced by women following severe perineal morbidity and associated birth trauma. Throughout each of the included studies, the description of their experiences were clearly distressing for women irrespective of the length of time that had passed since the perineal trauma had occurred, with some women reported as crying throughout the interviews (Salmon 1999, Williams et al. 2005, Herron-Marx et al. 2007, O’reilly et al. 2009).

Some women felt that the morbidities related to severe pelvic and perineal trauma were an acceptable consequence of childbirth, describing the postnatal body as different: ‘I take the view that it is a consequence of having a baby; that your body is never the same again. But it is worth it; I don’t mind paying that price because it is not really a handicap’ (Herron-Marx et al. 2007, p. 330). However, the majority of women who participated in the studies were reported to be upset, angry, tired, frustrated, resigned, and experiencing a sense of loss. ‘The day the consultant told me I had the vaginas of a 60 year old, I went home and cried. I felt tired, weary and I was in pain. My baby was fine, but I was a wreck. I felt very low, maybe not clinically depressed but very low’ (Salmon 1999, p. 253).

Table 3 Relationship between themes identified in included studies and the meta-ethnographic synthesis themes.

<table>
<thead>
<tr>
<th>Herron Marx</th>
<th>O’Reilly</th>
<th>Williams</th>
<th>Salmon</th>
</tr>
</thead>
<tbody>
<tr>
<td>3, 5</td>
<td>1, 2, 3, 4</td>
<td>1, 2</td>
<td>1, 2, 3</td>
</tr>
<tr>
<td>1, 2, 3, 4</td>
<td>2, 3, 4</td>
<td>2, 3, 4</td>
<td>2, 3, 4</td>
</tr>
</tbody>
</table>

A sense of self-blame and resignation, was reflected throughout the words of the women. Some women felt that their omission to perform pelvic floor exercises with the regularity advised by physiotherapists and obstetricians resulted in ongoing symptomatology, such as urinary incontinence (Herron-Marx et al. 2007, O’reilly et al. 2009).

I suppose you start blaming yourself a little bit because if you don’t do the exercises...you do them for the first few weeks and then just forget about them...I’m hopeless with exercises; I just stopped, so I think it’s my fault...I feel as though I’ve neglected myself a little bit (Herron-Marx et al. 2007, p. 329).

The emotions that the women experienced as a result of severe perineal trauma was seen to alter the perception of the sexual self, with women describing that they felt aged prematurely, like a failure, as their morbidities and associated symptoms meant that they were unable to fulfill their partners needs for intimacy: ‘I feel really, I guess useless from that point of view. I get frustrated because I can’t [have sex]. I am broken and a failure’ (O’reilly et al. 2009, p. 2016). As a consequence of the unpredictability of symptoms related to postpartum morbidities, such as urinary incontinence and bowel leakage, women described how anxiety, embarrassment, and feelings of apprehension about intimate contact with their partners was overwhelming, resulting in avoidance of intercourse: it’s not because I don’t love you anymore, it’s just that I can’t bring myself to do it’ (Williams et al. 2005, p. 133).

In relation to sexual intimacy, women described their partners as being on a continuum from supportive and concerned, to fed up and indifferent (Herron-Marx et al. 2007). “He was no good. He was going: ‘I don’t want to know about all that.’ He wasn’t any help at all.” (Williams et al. 2005, p. 132). Some women described how their partners would demonstrate concern throughout the act of sexual intimacy. “He keeps saying to me: ‘Are you ok, you ok, you all right, you all right?’ Yeah, I’m not like...but ‘Yeah, I’m fine’. (Williams et al. 2005, p. 133). In response to this concern, women described that they either pretended that there was no problem, or found the constant concern of the partner distracting which in turn impacted negatively on the woman’s own sexual feelings leading to indifference. However, in some circumstances, the women explained that it was not the partner pressuring the woman for sexual intimacy, but the women themselves feeling an obligation to participate in intercourse. The women were concerned that they felt they were not fulfilling their partner’s sexual needs in their role as wife, despite the anxiety that they felt about the potential for perineal pain.
Women's experiences following severe perineal trauma

Women described feeling ‘dismissed’, ‘devalued’, and ‘disregarded’ (Salmon 1999, O’reilly et al. 2009). Women felt that the treatment options that were suggested to them by health professionals were inadequate, and this indicated to them that their experience of postpartum morbidity was perceived as trivial (Salmon 1999, O’reilly et al. 2009). Women felt that having their concerns repeatedly dismissed was how the health professionals coerced and trained the women to believe that postpartum morbidity was insignificant, and an acceptable consequence of childbirth (Salmon 1999, Herron-Marx et al. 2007): ‘To him [obstetrician] it [urinary incontinence] was perfectly normal but, I guess it is just that male thing. That is just what happens when you have a baby, and I have to live with it.’ (O’reilly et al. 2009, p. 217).

Women reported that health professionals used inappropriate, degrading, and at times, comments with sexual connotations, to dismiss their concerns further (O’reilly et al. 2009): ‘...my own GP, a woman, turned around and said, “Are you sure your partner never got into your doctor’s ear and said you know, just a little bit tighter”. How is that supposed to make you feel?’ (O’reilly et al. 2009, p.217).

The dismissive attitude of health professionals towards postpartum perineal morbidities as trivial and acceptable was seen as a shared cultural perspective, with women feeling unsupported by those that they wished to talk to about their problems and seek support from, such as their friends, aunts, and mothers, ‘It’s just one of those things that nobody discusses really.’ (Herron-Marx et al. 2007). Women felt there was an expectation that they just get on with it (Herron-Marx et al. 2007):

And you know what really annoys me, really to the point where I just want to scream is that if you try and talk to someone about it including your Mum or even some of your friends, especially the older women. They say like, ‘women have been doing it for many years, you know, they have managed to, can’t you?’ (O’reilly et al. 2009, p. 217)

The practicalities of the unpredictable perineum

Women described feeling ‘dismissed’, ‘devalued’, and ‘disregarded’ (Salmon 1999, O’reilly et al. 2009). Women felt that the treatment options that were suggested to them by health professionals were inadequate, and this indicated to them that their experience of postpartum morbidity was perceived as trivial (Salmon 1999, O’reilly et al. 2009). Women felt that having their concerns repeatedly dismissed was how the health professionals coerced and trained the women to believe that postpartum morbidity was insignificant, and an acceptable consequence of childbirth (Salmon 1999, Herron-Marx et al. 2007): ‘To him [obstetrician] it [urinary incontinence] was perfectly normal but, I guess it is just that male thing. That is just what happens when you have a baby, and I have to live with it.’ (O’reilly et al. 2009, p. 217).

Women reported that health professionals used inappropriate, degrading, and at times, comments with sexual connotations, to dismiss their concerns further (O’reilly et al. 2009): ‘...my own GP, a woman, turned around and said, “Are you sure your partner never got into your doctor’s ear and said you know, just a little bit tighter”. How is that supposed to make you feel?’ (O’reilly et al. 2009, p.217).

The dismissive attitude of health professionals towards postpartum perineal morbidities as trivial and acceptable was seen as a shared cultural perspective, with women feeling unsupported by those that they wished to talk to about their problems and seek support from, such as their friends, aunts, and mothers, ‘It’s just one of those things that nobody discusses really.’ (Herron-Marx et al. 2007). Women felt there was an expectation that they just get on with it (Herron-Marx et al. 2007):

And you know what really annoys me, really to the point where I just want to scream is that if you try and talk to someone about it including your Mum or even some of your friends, especially the older women. They say like, ‘women have been doing it for many years, you know, they have managed to, can’t you?’ (O’reilly et al. 2009, p. 217)

The practicalities of the unpredictable perineum

The theme ‘The practicalities of the unpredictable perineum’ explored the impact of unpredictable bodily actions such as uncontrollable and unexpected episodes of urinary and faecal incontinence as a result of trauma to the pelvic floor, and the impact of the unpredictable perineum on the planning of future pregnancies and mode of birth. Due to their unpredictable perineum, women described how they had to ‘manage’ their daily activities; this included restricting sporting activities as the risks of experiencing an unexpected episode of incontinence meant that some women
now needed to exercise in private. For women experiencing unpredictable episodes of incontinence, activities and social outings were limited to places where the location of toilets were known (Herron-Marx et al. 2007, O’Reilly et al. 2009), and as a result women viewed their postpartum bodies as unreliable. The unreliability of the pelvic floor meant that women felt a constant anxiety at experiencing urinary incontinence: ‘...and every time I felt like attempting anything I felt like I was going to wee myself.’ (Williams et al. 2005, p. 132).

Women described that the daily strategies they were required to put in place extended to their selection of clothing, for example clothing which would minimize the risks of exposure if an episode of incontinence was to occur in public, whilst also camouflaging the use of incontinence pads:

Well it [urinary incontinence] kind of confines me when it is time to go swimming... I can’t wear a pony liner in the water, because when you get out of the water, which I have tried obviously it soaks up all this water and when you are walking out, there is all this water, it is really embarrassing... (O’Reilly et al. 2009, p. 2016)

For women who had experienced severe perineal trauma or an associated postpartum morbidity, they felt frightened and anxious about the future pregnancies and births, these feelings were expressed by both women who were already pregnant, and women discussing the possibility of a future pregnancy (Salmon 1999, Williams et al. 2005). These fears were expressed specifically in relation to the size of the subsequent child and the potential impact that this would place on the risk of experiencing subsequent trauma and/or requiring an episiotomy or caesarean section: ‘But I am really worried about this one. I said to my midwife you know I am a bit apprehensive about it and don’t know which way to go. And she said the decision is up to you if it’s a big baby, if you are measuring bigger than you were with [previous baby] I’d opt for a caesarean...’ (Williams et al. 2005, p. 130). The lack of information given to the women, and the conflicting opinions of health professionals in relation to the subsequent mode of birth, were seen to exacerbate the levels of apprehension and anxiety experienced by women.

Despite the feelings of fear and anxiety expressed by women when considering a subsequent birth, the majority of women indicated a preference for a vaginal birth despite their previous experience of severe perineal trauma: ‘I can’t remember who I spoke to but they said the way they are edging towards is to go for the natural delivery with an episiotomy so I am in two minds thinking I don’t want to have a caesarean if I don’t need one, but I will try and do it naturally.’ (Williams et al. 2005, p.130). For some women, inconsistent advice and a lack of support from health professionals, resulted in them choosing a mode of birth that they subsequently regretted: ‘The doctor sort of said to me it was up to me, but started saying that I’ve healed ok after the third degree from last time, [but] I might not heal this time and all the bad points if I hadn’t healed. That’s when I said caesarean, and that’s my biggest regret.’ (Williams et al. 2005, p. 134).

Discussion

This meta-ethnographic synthesis, which has synthesized the findings of four qualitative papers, has emphasized the complex physical health, social and emotional experiences of women who sustain a physical morbidity such as severe perineal trauma, an area that despite the extensive physiological and psychological impact this has on women, little research has been undertaken. The process of reciprocal translation (Noblit & Hare 1988) identified thematic representations which highlighted the social isolation, feelings of embarrassment, and depression experienced by women who have sustained a postpartum physical morbidity, including severe perineal trauma. This social isolation appeared to have occurred as a result of the perception for women that uncontrollable bodily functions as a result of severe perineal trauma were inappropriate for discussion, and therefore perceived as a cultural ‘taboo’, this was reported to impact upon the levels of support available to the women from family, friends, and health professionals’ inclusive (Salmon 1999, Williams et al. 2005, Herron-Marx et al. 2007, O’Reilly et al. 2009).

Severe perineal trauma appeared to affect not only physiological and psychological well-being, but also altered the women’s understanding of their identity as sexual beings. Women described a level of distress and anxiety at their unpredictable bodies, and this impacted upon their intimate relationships with their partners and their sexual identity as women and wives. The unpredictable nature of their bodies also impacted on their daily living and social activities; similar findings have been reported by Way (2011) in the qualitative study examining women’s experiences of their perineum following birth and their subsequent return to normality (Way 2011). Recent research has reported similar findings in that the degree of perineal trauma and associated symptomatology, specifically incontinence of flatus, liquid, and solid stool, has a direct impact on the quality of life for women (Samarasekera et al. 2008, Kumar 2011). The line of argument that we take is that the negative societal construct around symptoms following severe perineal
trauma mean women’s experiences are often unspoken and this can lead to feelings of shame and isolation thus perpetuating an ongoing invisibility.

Severe perineal trauma, women, and the embodied self
In the included studies, women reported that they were embarrassed about their symptoms and consequently did not always seek help. Other researchers (Groom & Paterson-Brown 2002, Stevenson 2010) identify that under reporting by women is due to the nature of the symptoms. Similarly, studies related to urinary incontinence, have identified several reasons for not seeking help including embarrassment, the perception by women that incontinence is a normal consequence of ageing and being female, and that urinary incontinence is something that can be managed by the woman without treatment (Peske et al. 1999, Groom & Paterson-Brown 2002, Melville et al. 2008). Melville et al. (2008) suggest that for some women who experience urinary incontinence there is a perception that the ongoing symptoms are as a result of the personal characteristics or behaviours such as pelvic floor exercises or as a result of weight gain (Melville et al. 2008). As Bartkey (1997) describes: ’Thus, a measure of shame is added to a woman’s sense that the body she inhabits is deficient: she ought to take better care of herself, she might after all have jogged that last mile’ (Bartkey 1997, p. 139). This reluctance to seek help was reported to impact upon the levels of support available to the women from family, friends, and health professionals’ inclusive (Salmon 1999, Williams et al. 2005, Herron-Marx et al. 2007, O’Reilly et al. 2009).

Women report that they took action to conceal and control unwanted bodily excretions. Menstruation, menopause, pregnancy, and childbirth, are a time when bodily functions are altered, and research has described how women will take efforts to conceal body functions to conform to societal norms (Martin 1997, Bailey 2001). A study conducted by Rizk et al. (2001) examining the recognition, incidence, and the socio demographic behaviours of United Arab Emirates females with faecal incontinence, described similar activities to those reported in this meta-ethnographic synthesis, such as the wearing of incontinence pads, frequent washing, stopping work, and reducing daily food intake (Rizk et al. 2001). Recent literature has critiqued the cultural consensus that leaking, messy and ‘dirty’ bodies must be managed and hidden (Draper 2003). The leakage of female fluids is seen as manifesting the uncontrollable body, as Lupton (1995) states: ’...the dirty body, is a horror, a source of loathing and disgust, a thing whose boundaries are leaky and uncontrolled and threaten to contaminate others’ (1995: 47). These statements support our line of argument that feelings of shame and isolation perpetuate invisibility for women experiencing ongoing morbidity following severe perineal trauma.

Literature has also described the impact that childbirth, and specifically the occurrence of perineal trauma, can have on sexual functioning for women and their partners following childbirth (Signorello et al. 2001, Rathfisch et al. 2010). Research conducted by Hicks et al. (2004) indicated that between 22-86% of women experience sexual difficulties following birth (Hicks et al. 2004). Signorello et al. (2001) reported that at 3 months postpartum, a 30% increase of dyspareunia was reported by women who sustained second degree trauma in comparison to women who did not sustain perineal trauma; for women with third degree trauma this incidence was reported to increase by 270% (Signorello et al. 2001). In addition, Signorello et al. (2001) reported the percentage of couples who have resumed sexual intercourse by 6 weeks postpartum with an intact perineum was 54%; with a second degree tear 39% had resumed sexual intercourse, and for women with third or fourth degree perineal trauma only 25% had resumed intercourse by 6 weeks (Signorello et al. 2001). Physically, sexual difficulties are related to reduced vaginal lubrication and dyspareunia, while the psychological impact of severe perineal trauma can result in a reduced desire for sexual activities due to a fear of pain, dyspareunia, and birth trauma (Rathfisch et al. 2010). Williamson et al. (2008) suggests that there is a lack of support available to women experiencing sexual difficulties in the postpartum period, and this is due to feelings of embarrassment by the woman and a reluctance on the part of the health professional to give support in this area (Williamson et al. 2008).

Grabowska (2009) describes that during the early postpartum period a woman following birth needs to be enveloped in nurturing support from those close to her, particularly her partner. However, what the woman may in fact face is a rejection, and the meta-ethnographic synthesis highlights how women, particularly in relation to sexual intimacy, felt that it was their obligation as women and wives to ‘fulfil’ their role despite feeling levels of anxiety as a result of experiencing, or the fear of experiencing, perineal and/or vaginal pain during intercourse (Grabowska 2009).

Interactions with health professionals: who cares about the perineum?

The findings of this meta-ethnographic synthesis indicate that the actions of health professionals caring for women
What is already known about this topic

- Severe perineal trauma is defined as a third degree tear, which involves injury to the perineum involving the anal sphincter complex; or a fourth degree tear, which involves injury to the perineum involving the external, internal, and epithelium of the anal sphincter.
- Internationally, the incidence of severe perineal trauma is reported to range from 0-5-7%.
- For women who experience severe perineal trauma the associated long-term physical morbidity can be debilitating and socially isolating.

What this paper adds

- Severe perineal trauma has an impact upon women’s self-identity, sexuality, and consequently often has an impact upon their relationship with their partner, family, and friends.
- As a result of the symptoms resulting from severe perineal trauma, women face a lack of support and social isolation during the postnatal period.
- Women report that negative or demeaning interaction with health professional’s impact on their sense of self and their likelihood of seeking ongoing treatment.

Implications for practice and/or policy

- Community-based support for women experiencing morbidities related to severe perineal trauma, which involves collaboration between health services and allied health to give long-term support for women, may be beneficial.
- Further research is required examining the experiences for women following severe perineal trauma as a marginalized group, and the potential impact this may have on their role as women, wives, and mothers.
- Midwives and obstetricians should ensure that timely and comprehensive education is provided to women in the immediate postnatal period about the degree of perineal trauma, details of the repair, subsequent and ongoing physical care, and potential morbidities, in the aim of encouraging women to seek support when required.

who have experienced severe perineal trauma have a profound impact upon the physical and psychological experience of the woman. Women reported a consistent lack of support from health professionals during the postpartum period, and it appeared that the dismissive approach by many health professionals resulted in women feeling disregarded and devalued. This reinforcement of the negative societal construct around symptoms following severe perineal trauma results in women not speaking about their experiences. The distress and fear that women reported parallels that described by women who have experienced a traumatic birth (Elmir et al. 2010). The experience of suturing for the women included in this synthesis was often traumatic, impacting upon their identity as women and sexual beings, represented in the description of the perineum as damaged and aged. Reports of health professionals actions leading to feelings of fear and a lack of control during suturing are very concerning and may reflect the well-reported paternalistic discourse of childbirth (Kitzinger 1997, Martin 1997).

During the postpartum period, the focus of the health professional is reported to shift from the well-being of the pregnant woman and foetus, to the well-being of the newborn (Woollett & Nicolson 2007). Woollett and Nicolson (2007) suggest that this focus on newborn health and maternal-infant attachment is as a result of the societal expectation that women will make a successful transition from woman to mother, and ‘return to normal’ following birth, therefore the shift of focus to the newborn is justified (Woollett & Nicolson 2007). However, research has identified the complexities of the postpartum period for women, particularly for those who experience complications, which may extend up to and beyond 6 months postpartum, such as depression, exhaustion, perineal pain, and breastfeeding issues (Thompson et al. 2002, Schmied et al. 2009).

Strengths and limitations

As an interpretive process, meta-ethnographies are becoming increasingly popular, however, there remains controversy as it has been argued that a meta-ethnography is merely the transference of data from one format to another and reductionist in nature (Noblit & Hare 1988, Walsh & Downe 2005, Downe 2008). We suggest that a strength of this meta-ethnographic synthesis is that it has highlighted the needs for women following severe perineal trauma through the use of the synthesis process, and adding to, as described by Downe (2008), to ‘the general sum of knowledge’ (Downe 2008, p. 8), and these findings were achieved using the methods outlined by Noblit and Hare (1988) of reciprocal translation and refutational investigation, similar or contrasting themes or metaphors were identified (Noblit & Hare 1988).
Limitations to this meta-ethnographic synthesis include the small number of qualitative papers that were available to be included in this analysis, that one paper was of a lesser quality than the others, and that the search was limited to the English language only. The participants in one paper were all recruited through a perinatal support clinic and therefore the findings may not be generalizable (Williams et al. 2005).

Conclusion
The three overarching themes identified in this meta-ethnographic synthesis highlight that for women who experience severe perinatal trauma and associated postpartum morbidities due to childbirth, there is a profound impact on both their physiological and psychological well-being. However, it would appear that there is a lack of support for women with health professionals dismissive of such concerns, and as a result these women experience social exclusion and marginalization due to symptoms related to untreated postpartum morbidities. These findings support our line of argument that women experiencing ongoing morbidities following severe perinatal trauma feel shame and isolation, which in turn perpetuates an ongoing invisibility.

The lack of literature investigating the experiences of women following severe perinatal trauma as a marginalized group, and the impact this has on their role as women and wives, identifies the need for future research to be conducted into this area. Recommendations for future practice include the establishment of specialized perinatal care clinics that give consistent and collaborative care for women (Williams et al. 2005, Thakar & Sultan 2007).

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Author contributions
All authors meet at least one of the following criteria (recommended by the ICMJE: http://www.icmje.org/ethical_1author.html) and have agreed on the final version:

- substantial contributions to conception and design, acquisition of data, or analysis and interpretation of data.

• drafting the article or revising it critically for important intellectual content.

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Table S1. A critical appraisal of included papers.
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References

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Women’s experiences following severe perineal trauma


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3.2 Chapter conclusion

This chapter presented a meta-ethnographic synthesis of qualitative papers published in a paper titled, ‘Women’s experiences of severe perineal trauma: a meta-ethnographic synthesis. The paper described the impact of SPT on the lives of women and the experiences of interactions with health care providers. The findings suggest that, for some women who experience SPT, the physical and psychological outcomes can be complex and result in social isolation and marginalisation. Women describe feeling dismissed, disregarded and dehumanised following their interactions with health care providers, highlighting the need for health professionals to be mindful of their language and actions during suturing and the postpartum period when caring for women who sustain SPT. The following chapter presents the published findings of Stage 2(a) of the study, an investigation of linked data.

4.1 Publication relevance to thesis


This paper presents the findings of a linked data population based cohort study which examined perineal outcomes for women who gave birth in New South Wales between January 2000 and July 2008 recorded in the Midwives Data Collection (MDC).
Risk of recurrence, subsequent mode of birth and morbidity for women who experienced severe perineal trauma in a first birth in New South Wales between 2000 --2008: a population based data linkage study


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Risk of recurrence, subsequent mode of birth and morbidity for women who experienced severe perineal trauma in a first birth in New South Wales between 2000 –2008: a population based data linkage study

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Abstract

Background

Severe perineal trauma occurs in 0.5-10% of vaginal births and can result in significant morbidity including pain, dyspareunia and faecal incontinence. The aim of this study is to
determine the risk of recurrence, subsequent mode of birth and morbidity for women who experienced severe perineal trauma during their first birth in New South Wales (NSW) between 2000 – 2008.

**Method**

All singleton births recorded in the NSW Midwives Data Collection between 2000–2008 (n=510,006) linked to Admitted Patient Data were analysed. Determination of morbidity was based upon readmission to hospital within a 12 month time period following birth for a surgical procedure falling within four categories: 1. Vaginal repair, 2. Fistula repair, 3. Faecal and urinary incontinence repair, and 4. Rectal/anal repair. Women who experienced severe perineal trauma during their first birth were compared to women who did not.

**Results**

2,784 (1.6%) primiparous women experienced severe perineal trauma during this period. Primiparous women experiencing severe perineal trauma were less likely to have a subsequent birth (56% vs 53%) compared to those not who did not (OR 0.9; CI 0.81-0.99), however there was no difference in the subsequent rate of elective caesarean section (OR 1.2; 0.95-1.54), vaginal birth (including instrumental birth) (OR 1.0; CI 0.81-1.17) or normal vaginal birth (excluding instrumental birth) (OR 1.0; CI 0.85-1.17). Women were no more likely to have a severe perineal tear in the second birth if they experienced this in the first (OR 0.9; CI 0.67-1.34). Women who had a severe perineal tear in their first birth were significantly more likely to have an ‘associated surgical procedure’ within the ≤12 months following birth (vaginal repair following primary repair, rectal/anal repair following primary repair, fistula repair and urinary/faecal incontinence repair) (OR 7.6; CI 6.21-9.22). Women who gave birth in a private hospital compared to a public hospital were more likely to have an ‘associated surgical procedure’ in the 12 months following the birth (OR 1.8; CI 1.54-1.97), regardless of parity, birth type and perineal status.

**Conclusion**

Primiparous women who experience severe perineal trauma are less likely to have a subsequent baby, more likely to have a related surgical procedure in the 12 months following the birth and no more likely to have an operative birth or another severe perineal tear in a subsequent birth. Women giving birth in a private hospital are more likely to have an associated surgical procedure in the 12 months following birth.

**Keywords**

Severe perineal trauma, subsequent birth, postpartum morbidities, risk of recurrence.

**Background**

Severe trauma to the perineum during vaginal birth can occur spontaneously or as a result of obstetric intervention [1,2]. Severe perineal trauma (SPT) is defined as a third degree tear which involves injury to the perineum involving the anal sphincter complex (this is further graded as 3a, 3b or 3c depending on the extent of external and internal anal sphincter
involvement); or a fourth degree tear which involves injury to the perineum involving the external, internal and epithelium of the anal sphincter [3].

While approximately two thirds of Australian women will experience some trauma to the perineum during a vaginal birth [4], around 1.7% experience severe perineal trauma (SPT). This rate ranges from 1.5% in Queensland, to 2.3% in the Australian Capital Territory [4]. While exact figures reporting the incidence of severe perineal trauma, with associated damage to the anal sphincter, are unclear, on an international scale the incidence is reported to range from between 0.5 – 10% [5,6]. Andrews et al. (2006) report that the incidence of severe perineal trauma increases to up to 19% in centres where midline episiotomies are performed [7].

**Risk factors for severe perineal trauma**

Risk factors associated with an increased incidence of severe perineal trauma include parity (primiparous), maternal age (very young and old), nutritional status, previous experience of perineal trauma, fetal weight, abnormal collagen synthesis and gender of the fetus [5,8,9]. Whilst literature reports that women of Asian ethnicity are at an increased risk of sustaining severe perineal trauma when giving birth in Western countries, controversy remains as to whether this risk remains when these women birth within their country of origin [10,11]. Intrapartum risk factors include fetal presentation, episiotomy (particularly midline), instrumental birth, prolonged second stage of labour, birth position during second stage, and obstetric emergencies such as shoulder dystocia [8,12-15].

It has been suggested that women who have experienced severe perineal trauma may be fearful of experiencing a subsequent pregnancy and birth; this fear is reported to be based upon the risk of sustaining subsequent perineal trauma, and that these women may require an episiotomy or a caesarean section [16,17]. Some women who experience severe perineal trauma express a preference for a vaginal birth subsequently, despite their fears regarding risk of recurrence [16]. There are contradictory findings reported in the literature regarding the risk of recurrence for women who have experienced third or fourth degree perineal trauma [18-21]. A review conducted by Edwards et al. (2006) reviewed 271 cases, from 1991 to 2003, of women who experienced a subsequent labour and birth following severe perineal trauma with the first birth. The authors reported that the rate of recurrence was not statistically significant when compared to women experiencing initial severe perineal trauma (2.4% vs 3.3%, OR 0.72, 95% CI 0.33 – 1.59). Of those that did go on to experience recurrent trauma, risk factors included age, weight of the woman, birth weight of the newborn, the use of episiotomy and instrumental births [19]. A cohort study conducted by Baghestan et al. (2011) reported that an obstetric history of severe perineal trauma in the first or second birth increased the likelihood of repeat trauma occurring in the third birth. Likewise women who experienced severe perineal trauma were less likely to have a second pregnancy compared with women who had no history of severe perineal trauma (66.7% versus 76.9%); however these findings were not statistically significant [18]. The risk is reported to increase in large maternity units (>3000 births per annum), when the newborn weight is above 3500 grams, and when forceps are used during the second stage of labour [18,19,21].

The aim of this study was to determine the risk of recurrence, subsequent mode of birth and morbidity for women who experienced severe perineal trauma in a first birth in NSW between 2000–2008.
Methods

Data sources

Birth data for the time period July 1st 2000 until June 30th 2008 of all singleton births was provided by NSW Department of Health as recorded in the NSW Midwives Data Collection (MDC). This legislated, population based surveillance system contains maternal and infant data on all births of ≥400 grams birth weight or ≥20 weeks gestation.

The recording of perineal status was altered on the MDC in 2006. Prior to 2006, perineal status was recorded as intact/graze, 1st degree tear, 2nd degree tear, 3rd degree, 4th degree tear, episiotomy and combined episiotomy and tear. Post 2006 combined episiotomy and tear was removed. The two versions of the data were merged for the purpose herein. The data item ‘Episiotomy Yes/No’ was also utilised. The accuracy of the recording of perineal status has previously been shown to have a kappa of 0.84 and 0.82 in two separate and individual studies [22,23]. The positive predictive value (PPV) of 1st, 2nd, 3rd and 4th degree tears have been reported as 76.6, 96.6, 72.8 and 100.0 respectively. This PPV provides an overview of the validity of the recording of perineal status in various sources including electronic and paper based medical records. Only women recorded as having a vaginal birth were included in this study.

Data on all hospital admissions was provided by the census data collection, the Admitted Patient Data Collection (APDC). The clinical data component of the APDC utilises the International Classification of Diseases – Australian modification (ICD-10-AM). Probabilistic linkage of the two datasets was undertaken by the Centre for Health Record Linkage. The validity and accuracy of this process has been examined and these datasets have low rates of missing data when compared to medical records and high levels of agreement [22,23].

Seven thousand APDC codes related to all patient admissions over the period from 2000-2008 in NSW were sorted individually by the first author, and coded under sixteen subheadings. The purpose of sorting these codes was to determine the reason for, and frequency of, admission for women within a 12 month time period following birth for procedures related to perineal/pelvic floor trauma. The identified subheadings were: Nervous System; Skin; Skeleton; Renal/Ureter/Bladder; Fertility/Pregnancy; Miscellaneous (this included such codes as oncology related therapies); Eyes; Ears; Respiratory; Cardiac; Gastrointestinal; Pelvic/Sphineter/Urthral; Lymphatics; Breast; Psychiatric and Male Specific Codes. Any procedural codes relating to diagnosis and repair of the initial trauma were not included in the final coding categories. A list of potential Medicare Benefit Schedule (MBS) procedural codes was identified by the first author. This initial sorting of codes was completed and independently reviewed by two of the co-authors for accuracy. This list was then reviewed independently by three specialists in fields related to perineal trauma and outcomes including: 1. A midwife running a postnatal specialist perineal trauma clinic, 2. An obstetrician, and 3. A colorectal surgeon. Through this consensus process a refined list of codes that were specifically associated with therapies and treatment for morbidities potentially occurring as a result of severe perineal trauma from subheadings Renal/Ureter/Bladder, Fertility/Pregnancy, and Pelvic/Sphineter/Urthral was agreed upon. These codes were then grouped into the following four categories related by procedure and physiology: 1. Vaginal repair, 2. Fistula repair, 3. Faecal and urinary incontinence repair, and 4. Rectal/anal repair. There were 34
subgroups/diagnostic codes for vaginal repair, eight for fistula, eight for faecal and urinary incontinence and 11 for rectal/anal repair.

The first pregnancy recorded in the MDC with vaginal birth documented as the mode of birth was considered the index pregnancy for this dataset regardless of parity. For this reason, sub-analyses were undertaken according to parity.

Ethical approval was obtained from the NSW Population and Health Services Research Ethics Committee, Protocol No.2010/12/291.

Data analysis

Descriptive analyses of short and long term morbidity associated with all types of perineal trauma was produced utilising SPSS v.19 (IBM). Frequency distributions were used to classify the population and descriptive statistics the morbidity outcomes. Relative risk was calculated between factors and events, Odds Ratios (OR) are reported for rare outcomes. Due to the number of associations examined, the level of statistical significance was set at <0.001.

Results

Between July 1st 2000 and June 30th 2008 there were 510,006 vaginal births. Nearly all of these births occurred in hospital (95%) and 71% of the women were born in Australia. Of the women giving birth vaginally 14.2% had an instrumental birth and 0.6% had a vaginal breech birth (Table 1).

Table 1 Demographics and mode of birth of women giving birth in NSW between 2000-2008

<table>
<thead>
<tr>
<th>Demographic/Type of Birth</th>
<th>All women</th>
</tr>
</thead>
<tbody>
<tr>
<td>No of births</td>
<td>510,006</td>
</tr>
<tr>
<td>Age of women at delivery (Mean and SD)</td>
<td>29.7 (5.55)</td>
</tr>
<tr>
<td>% Primiparous</td>
<td>40.6%</td>
</tr>
<tr>
<td>Place of birth</td>
<td></td>
</tr>
<tr>
<td>Hospital</td>
<td>94.5%</td>
</tr>
<tr>
<td>Birth Centre</td>
<td>3.30%</td>
</tr>
<tr>
<td>Planned Birth Centre transferred to hospital</td>
<td>1.30%</td>
</tr>
<tr>
<td>Planned Home Birth</td>
<td>0.20%</td>
</tr>
<tr>
<td>Planned Home Birth transferred to Hospital</td>
<td>0.01%</td>
</tr>
<tr>
<td>Born Before Arrival</td>
<td>0.60%</td>
</tr>
<tr>
<td>Type of Birth</td>
<td></td>
</tr>
<tr>
<td>Normal Vaginal Delivery</td>
<td>85.3%</td>
</tr>
<tr>
<td>Forceps</td>
<td>4.8%</td>
</tr>
<tr>
<td>Ventouse</td>
<td>9.4%</td>
</tr>
<tr>
<td>Vaginal Breech</td>
<td>0.6%</td>
</tr>
<tr>
<td>Country of Birth of Mother</td>
<td></td>
</tr>
<tr>
<td>Australia</td>
<td>71.6%</td>
</tr>
<tr>
<td>New Zealand</td>
<td>2.6%</td>
</tr>
<tr>
<td>England</td>
<td>2.2%</td>
</tr>
<tr>
<td>Country</td>
<td>Rate (%)</td>
</tr>
<tr>
<td>-----------</td>
<td>----------</td>
</tr>
<tr>
<td>Vietnam</td>
<td>2.2%</td>
</tr>
<tr>
<td>China</td>
<td>2.1%</td>
</tr>
<tr>
<td>Lebanon</td>
<td>2.1%</td>
</tr>
<tr>
<td>Other</td>
<td>17.2%</td>
</tr>
</tbody>
</table>

The overall incidence of severe perineal trauma in women giving birth to singleton infants from 2000–2008 was 1.6% (n=2784) for primiparous women (Figure 1). Primiparous women experiencing severe perineal trauma were less likely to have a subsequent birth (56% vs 53%) compared to those not experiencing it (OR 0.9; 95% CI 0.81-0.99). There was no difference in the rate of elective caesarean section (OR 1.2; 95% CI 0.95-1.54), vaginal birth (including instrumental birth) (OR 1.0; 95% CI 0.81-1.17) or normal vaginal birth (excluding instrumental birth (OR 1.0; 95% CI 0.85-1.17). Women were no more likely to have a severe perineal tear in the second birth if they experienced this in the first (OR 0.9; 95% CI 0.67-1.34) (Table 2).

**Figure 1 Flow diagram of mode of birth and perineal outcomes following index birth with severe perineal trauma and without.**

**Table 2 Outcomes for women in subsequent births following a previous severe perineal trauma**

<table>
<thead>
<tr>
<th>Outcome</th>
<th>OR</th>
<th>95% CI</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any subsequent birth</td>
<td>0.9</td>
<td>(0.81-0.99)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Elective C/S</td>
<td>1.2</td>
<td>(0.95-1.54)</td>
<td>0.95</td>
</tr>
<tr>
<td>Vaginal birth rate</td>
<td>1.0</td>
<td>(0.81-1.17)</td>
<td>0.39</td>
</tr>
<tr>
<td>Normal vaginal birth outcome</td>
<td>1.0</td>
<td>(0.85-1.17)</td>
<td>0.50</td>
</tr>
<tr>
<td>SPT in second delivery</td>
<td>0.9</td>
<td>(0.67-1.34)</td>
<td>0.74</td>
</tr>
</tbody>
</table>

Primiparous women who had a severe perineal tear in their first birth were significantly more likely to have an ‘associated surgical procedure’ in the 12 months following birth (vaginal repair following primary repair, rectal/anal repair following primary repair, fistula repair and urinary/faecal incontinence repair) compared to women who did not have a severe perineal tear (4.1% vs 0.6%). In the second pregnancy following the index birth where the primary severe perineal trauma occurred, 12 women following a vaginal birth (1.1%) and one woman following a caesarean section (0.85%) had an admission ≤12 months following the second birth for an ‘associated surgical procedure’.

Overall, both primiparous and multiparous women admitted for an ‘associated surgical procedure’ ≤12 months post birth were more likely to be older (29.7 vs 30.8), primiparous (49.5% vs 40.6%), not to smoke (11.9% vs 15.8%) and have a private hospital admission for the procedure (34.5% vs 20.7%) (Table 3). Women who gave birth in a private hospital during the eight year period were more likely to have an ‘associated surgical procedure’ in the 12 months following the birth (OR 1.8; 95% CI 1.54-1.97), regardless of parity, birth type and perineal status.
Table 3 Demographic and medical factors associated with admission for an associated surgical procedure in the 12 months following a birth

<table>
<thead>
<tr>
<th></th>
<th>All vaginal births</th>
<th>Admitted within 12 months post birth</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>597508</td>
<td>2498</td>
<td></td>
</tr>
<tr>
<td>Age (years)</td>
<td>29.7 (5.55SD) (12−55 range)</td>
<td>30.8 (5.14SD) (15−48 range)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>% Primiparous</td>
<td>40.6%</td>
<td>49.5%</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Smoking</td>
<td>15.8%</td>
<td>11.9%</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Hypertensive Disorder of Pregnancy</td>
<td>4.8%</td>
<td>4.4%</td>
<td>NS</td>
</tr>
<tr>
<td>Gestational diabetes</td>
<td>3.9%</td>
<td>3.6%</td>
<td>NS</td>
</tr>
<tr>
<td>Private hospital admission</td>
<td>20.7%</td>
<td>34.5%</td>
<td>&lt;0.001</td>
</tr>
</tbody>
</table>

Discussion

The data in this study indicates that women who experience severe perineal trauma with their first birth were significantly less likely to experience a subsequent pregnancy and birth during the 8 year period (56% versus 53%). Similar findings have been reported by Baghestan et al. (2011) and Elfaghiti et al. (2004). Elfaghiti et al. (2004) reported this finding as concerning, and therefore suggested that providing women with the option of elective caesarean sections may result in increased subsequent pregnancies for women who had experienced previous birth trauma [21]. Whilst the findings reported above are statistically significant, the reported difference between groups may have limited clinical significance. Further, it is possible that the women who gave birth in 2008 in the dataset have experienced a subsequent pregnancy and birth after data collection ceased. Removal of these women from the dataset was considered however due to the relatively rare occurrence of severe perineal trauma it was decided to include these women.

A prospective cohort study conducted by Gottvall and Waldenstrom (2002) investigated whether the experience of the first birth impacted upon women choosing to experience subsequent pregnancies and births [24]. The authors reported that women who described their first birth experience as negative were significantly less likely to experience a subsequent pregnancy, and for those that did, there was a larger interval between the first and second births which supports the findings of this study [24]. In a qualitative study conducted by Rilby et al. (2012) exploring the feelings and fears experienced by women planning a subsequent pregnancy and birth, while women report feeling fearful particularly in relation to anticipated pain or potential complications to either themselves or the newborn baby, they were motivated by the positive experience of a vaginal birth and the newborn baby. Some women however did report that due to their fears and previous experiences, they would opt for a caesarean birth [25].

Elective caesarean or normal vaginal birth in subsequent pregnancy

The findings of this study report that for women who experience third and/or fourth degree perineal trauma there is no difference between elective caesarean section and normal vaginal birth rate for subsequent deliveries. For women who are symptomatic for urinary, flatus or faecal incontinence, or have findings that deviate from normal via manometric or endoanal ultrasonography associated with severe perineal trauma, it is suggested that an elective caesarean section should be recommended by the health care professional [3]. However,
debate continues as to the most appropriate management of the subsequent mode of birth following severe perineal trauma, with discussions focused around the protective mechanisms, potential morbidities and increased risk of subsequent perineal trauma associated with operative vaginal and vaginal births [3,18,20,21,26].

Concerns exist as to the ongoing integrity of the pelvic floor and anal sphincter function if a woman is to experience a subsequent vaginal birth [27]. In a study conducted by McKenna et al. (2003) looking at outcomes related to elective caesarean sections for women who have a history of severe perineal trauma, the authors suggested that the risks associated with a repeat outcome of severe perineal trauma and the associated potential morbidities such as faecal incontinence outweighs the potential morbidities that can occur as a result of an elective caesarean section [28]. In contrast, a study conducted by Scheer et al. (2009) investigated sphincter integrity via manometric assessment, associated function, and quality of life for women who were asymptomatic (n= 73), who experienced a subsequent birth following severe perineal trauma. The authors reported that there were no significant differences in sphincter integrity via manometry, or quality of life as reported by survey, following a subsequent vaginal birth; three women experienced repeat severe perineal trauma and one new internal sphincter defect was detected [26]. The data in our study was limited by small numbers so we could not examine morbidity in future pregnancies. In the second pregnancy following the index birth where the primary severe perineal trauma occurred, only 12 women following a vaginal birth (1.1%) and one woman following a caesarean section (0.85%) had an admission ≤12 months following the second birth for an ‘associated surgical procedure’.

There is also some evidence to suggest that following traumatic birth experiences, women may choose a vaginal birth over a caesarean section for subsequent births, and it is suggested that these choices may occur as a result of an understanding of the physiological and psychological benefits for both themselves and their newborns [16,29,30]. Women further report the benefits of vaginal birth as enabling initial bonding with their newborn infant; this is seen as particularly important by women who are planning a vaginal birth after caesarean [17,31]. It has been reported that women identify a strong link between labour and vaginal birth, femininity, and as a rite of passage to womanhood [30,31].

Risk of repeat SPT

In this study, in comparison to women who had not sustained severe perineal trauma during birth, women who experienced a third of fourth degree perineal tear were no more likely to experience severe perineal trauma in a subsequent pregnancy. Studies investigating the risk of recurrence of in subsequent births for women who have experienced severe perineal trauma vary widely in findings [18-20]. Studies by Edwards et al. (2006) and Scheer et al. (2009) support the findings in this study, while Lowder (2007) reported that women who had experienced severe perineal trauma with their index pregnancy, were at increased risk of subsequent perineal trauma in comparison to women with no history of perineal trauma (7.2% versus 2.3%). This risk of recurrence was increased as a result of episiotomy, malpresentation, shoulder dystocia, and birth weight greater than 3500 grams [19,20,26]. These associations have also been reported elsewhere [18,20,32].

Sociodemographic influences

In a previous study we found that women who gave birth in a private hospital compared to a public hospital were at greater risk of SPT compared to women who had no perineal trauma.
or minor perineal trauma (1st degree, vaginal/labial tear); however they were at no increased risk when compared to all women who did not experience SPT (9). Other studies have shown a protective effect of private hospital care on SPT rates [33] but have been criticised for methodological flaws, such as not including extensions of episiotomy in the data examined [34]. There are also concerns expressed by health practitioners that SPT is under-reported in private hospitals [35]. In this study we found that women who gave birth in a private hospital regardless of parity, mode of birth or degree of perineal trauma were more likely to be admitted for an ‘associated surgical procedure’ in the ≤12 months following birth. This could indicate under-reporting of severe perineal trauma in private hospitals or alternatively a higher tendency for those women who are socially advantaged to access surgical procedures following birth. We also noted older age, primiparity and non-smoking increased the chance of admission for an ‘associated surgical procedure’. While age and parity have been associated with increased risk of SPT in the literature [36] smoking has not, though it has been associated with lower birth weight babies [37]. Again these could be more social markers than causal factors with socially advantaged women being more informed about health care options and being more likely to be older and non-smoking.

**Best practice**

It has been suggested that best practice models of care for women who sustain severe perineal trauma include a referral for an endosal ultrasound and consultation with a colorectal surgeon in locations where specialist perineal care clinics are operational, and women can access supportive, collaborative care within the one facility [38].

**Limitations**

There are significant advantages of using population based datasets such as the MDC, including the size of the dataset, a well validated dataset and the anonymous nature of the results therein. The limitations are the limited number of variables that are included and the scarcity of specific information on potential confounders, specifically information regarding maternal weight and pregnancy weight gain and pre-existing medical conditions. This paper has reported that older age is associated with admission for an associated surgical procedure (30 years versus 31 years); whilst these findings are statistically significant the clinical significance is questionable. We are reassured by previous validation studies that perineal status is very accurately recorded [23,39,40]. There is also under reporting in some organisations making accurate ascertainment and comparison of SPT rates difficult.

**Conclusion**

In this study we found primiparous women experiencing severe perineal trauma compared to those who did not were less likely to have a subsequent birth, no less likely to have a normal vaginal birth in a subsequent pregnancy and no more likely to have a repeat SPT. Women who had a severe perineal tear in their first birth were however significantly more likely to have an ‘associated surgical procedure’ in the ≤12 months following birth and women who gave birth in a private hospital are also more likely to have an ‘associated surgical procedure’ in the 12 months following the birth. More research is needed to explore with women and health providers their decision making following a SPT to determine whether women are making the choice of a vaginal birth following a SPT or if health practitioners are influencing this choice. There is also an urgent need to explore the experiences of women who experience
a SPT and the impact of the morbidity observed in this study on their wellbeing. There is also limited information available about the ideal construction of health services for women experiencing SPT from the perspective of women and health providers.

**Competing interests**

The authors declare that they have no competing interests.

**Authors’ contributions**

HP participated in data review, design and drafting of manuscript as a component of a doctoral study. HD conceived of the study design, participated in design and drafting of manuscript. VS assisted with review of data. CT conducted statistical analysis and helped review the manuscript draft. CB advised and assisted with statistical analysis. AS, CK and MG provided expert review of coded data and assisted with writing the manuscript. All authors read and approved the final manuscript.

**Acknowledgements**

We thank Marc Gladman, colorectal surgeon, for his expertise and assistance.

**References**


4.2 Chapter conclusion

In this chapter I presented the findings of a linked data population based cohort study within a published paper titled, ‘Risk of recurrence, subsequent mode of birth and morbidity for women who experienced severe perineal trauma in a first birth in New South Wales between 2000 - 2008: a population based data linkage study’. This paper reported the increasing incidence of SPT across NSW within the time period of 2000 – 2008, the influence of SPT on subsequent pregnancies and modes of birth, and related morbidities requiring surgical repair. The following chapter presents the published findings of Stage 2(b) of the study, interviews with women who have sustained SPT.
Chapter Five: Findings: Women’s experiences following severe perineal trauma: a qualitative study.

5.1 Publication relevance to thesis


This paper presents the findings of interviews conducted with women who have sustained SPT. Three main themes were identified: ‘The Abandoned Mother’, ‘The Fractured Fairytale’, and ‘A Completely Different Normal’.
Women’s experiences following severe perineal trauma: a qualitative study

Holly Friddis, Virginia Schmied and Hannah Dahlen

Abstract

Background: Literature reports that the psychological impact for women following severe perineal trauma is extensive and complex; however, there is a paucity of research reporting on women’s experience and perspective of how they are cared for during this time. The aim of this study was to explore how women experience and make meaning of living with severe perineal trauma.

Methods: A qualitative interpretive approach using a feminist perspective guided data collection and analysis. Data were collected through semi-structured face-to-face interviews with twelve women in Sydney, Australia, who had experienced severe perineal trauma during vaginal birth. Thematic analysis was used to analyse the data.

Results: Three main themes were identified: The Abandoned Mother describes how women feel vulnerable, exposed and disempowered throughout the labour and birth, suturing, and postnatal period and how these feelings are a direct result of the actions of their health care providers. The Fractured Fairytale explores the disconnect between the expectations and reality of the birth experience and immediate postnatal period for women, and how this reality impacts upon their ability to mother their newborn child and the sexual relationship they have with their partner. A Completely Different Narrative discusses the emotional pathways women travel as they work to rediscover and redefine a new sense of self following severe perineal trauma.

Conclusion: How women are cared for during their labour, birth and postnatal period has a direct impact on how they process, understand and redefine a new sense of self following severe perineal trauma. Women who experience severe perineal trauma and associated postnatal morbidities undergo a transition as their maternal body boundaries shift, and the trauma to their perineum results in an extended physical opening whereby the internal becomes external, and that creates a continual shift between self and other.

Background

Severe trauma to the perineum (third and fourth degree tears), the area between the anus and the vagina, can occur spontaneously or as a result of obstetric intervention during vaginal birth [1,2]. Severe perineal trauma (SPT) is defined as a third degree tear, which involves injury to the perineum which extends to the anal sphincter complex; or a fourth degree tear, which involves injury to the perineum involving the external, internal and epithelium of the anal sphincter [3]. It is reported that internationally the incidence of SPT ranges from 0.5-10% [4,5]. While some women may experience no symptoms, other women may experience any or all symptoms including dyspareunia, stress or urge urinary incontinence, flatus and/or faecal incontinence, and are at risk of developing co-morbidities including pelvic organ prolapse and vesicovaginal fistulas [6-8].

There is a paucity of literature examining the experiences for women who sustain SPT in either the social sciences, midwifery, nursing or medical literature. A meta ethnographic study examining the experiences of women who had sustained a postpartum physical morbidity including SPT identified three major themes: ‘I am broken and a failure’, ‘Dismissed, devalued and disregarded’, and ‘The practicalities of the unpredictable perineum’ [9]. These themes highlighted that women who experience SPT and associated postpartum morbidities report this has a profound impact on both their physical and psychological wellbeing, and as a result women may experience...
social isolation and marginalisation particularly those 

women who experience ongoing morbidity.

Feminist philosophers have explored the physical and 

psychological transition that occurs during pregnancy 

and birth, and the impact this has on how women 

experience and reshape their sense of self [10-12]. Young 

describes the physical transition of the maternal body 

during pregnancy, and how this transformation challenges 

and shifts previously known body boundaries [12]. It has 

been described that a shifting of maternal body boundaries 

occurs during birth, with the pregnant body transitioning 

to that of the leaking postnatal body, where internal and 

external boundaries are shifted, and this results in a blurring 

between self and other [13,14]. Lupton and Schmied have 

examined women’s loss of self and boundary during 

the final moments of birth, at which time they become 

unclear about where they begin and end, and who or 

what the newborn baby is in relation to the maternal 

body [13]. When these boundaries do not close again, as 

in the case of resulting morbidity from SPT, there may 

be ongoing blurring between the self and other. 

The paucity of literature investigating the experiences 
of women following SPT as a marginalised group, and 

the impact this has on their role as women, wives and 

mothers, identified the need for future research to be 

conducted into this area. The aim of this study was to 

explore how women experience and make meaning of 

living with SPT.

Methods

A qualitative approach was selected as the most appropri-

ate methodology to guide the data collection and analysis 

for this study. The incorporation of an interpretive femin-

ist perspective allowed for the exploration of gender re-

lated oppression and marginalization, and valued the voice 
of the lived experience of women [15]. Feminist research 

incorporates a critical research approach that aims to 

understand and challenge the way in which individuals 

and groups experience the world, this understanding can 

facilitate opportunities to bring about change for members 
of marginalized groups [15,16]. The findings from a meta-

ethnographic study [9] informed the design of the ques-
tions that were asked of the women during the face to 

face interviews.

Data were collected during face to face interviews 

with twelve women who had experienced SPT following 

vaginal birth, data collection continued until saturation 

was reached. Participants contacted the first author in 

response to a flyer that was distributed from October 

2011 to April 2012 via social media (Facebook) and 

word of mouth through midwifery colleagues of the first 

author. In addition, snowball sampling was used as the 

participants suggested other women who may also be 

suitable to participate in the study.

The in depth interviews occurred at a time and place 

convenient to the woman and were recorded using a digital 

recording device. To ensure informed consent, 

participation in the interviews was self-determined by 

the women as a response to distribution of the informa-

tion sheet. Participants were then asked to read and sign 

the consent form if they agreed to participate. Partici-

pants were advised that all data would be de-identified 

during transcription of recording to protect identities. 

The purpose of the interviews was to explore the way 

women have experienced and understood SPT, and their 

interactions and experiences with health professionals 

and health services. Prior to and during the interview 

process, it was explained to all participants that the first 

author had sustained severe perinatal trauma and as a re-

sult experienced long term morbidities. As an “insider” 

this transparency enabled the ability for the first author 

to develop rapid rapport and establish relationships with 

the participants. Each interview was between one to two 

hours duration. The interviews were semi-structured, 

using open ended questions (Table 1) [17]. The use of 

open ended questions enable the complexities of the 

subjective experience relative to the individual’s own

<table>
<thead>
<tr>
<th>Table 1 Interview questions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. With which baby did you experience a third or fourth degree perineal tear? Can you tell me about your experience?</td>
</tr>
<tr>
<td>2. Following the birth, at what stage were you told that you had sustained a third or fourth degree tear?</td>
</tr>
<tr>
<td>3. Did anyone explain to you how to care for your tear and what treatments you may require in hospital?</td>
</tr>
<tr>
<td>4. Did you have antibiotics?</td>
</tr>
<tr>
<td>5. What advice were you given when you were preparing to discharge the hospital?</td>
</tr>
<tr>
<td>6. Did you see an early childhood nurse/midwife following discharge? Yes the third or fourth degree tear spoken about?</td>
</tr>
<tr>
<td>7. What symptoms did you experience that you feel were due to the tear?</td>
</tr>
<tr>
<td>8. How did these symptoms affect your ability to care for your baby? Do household chores? Go out?</td>
</tr>
<tr>
<td>9. How did this experience impact upon your relationship with your partner? How long was it before you felt comfortable to have intercourse? Was it uncomfortable?</td>
</tr>
<tr>
<td>10. What services did you access? Do you access for support or treatment of these symptoms?</td>
</tr>
<tr>
<td>11. Next babies: Have you had any more children following the third or fourth degree tear? Were these babies vaginal births or caesareans? Who made the decision to have a vaginal birth/caesarean? Were you given an epidural?</td>
</tr>
<tr>
<td>12. Do you feel about the support you were given in hospital?</td>
</tr>
<tr>
<td>13. Is there anything you would like health workers to know that might help them when they care for women like you?</td>
</tr>
<tr>
<td>14. What do you wish you had known?</td>
</tr>
<tr>
<td>15. How do you see yourself as a person now?</td>
</tr>
</tbody>
</table>
postpartum morbidities and related symptoms, to be uncovered and explored [18,19].

Recordings of interviews were listened to and transcribed verbatim, the transcripts were read thoroughly to allow the researcher to become immersed in the data [20,21]. Data were analysed using thematic analysis [22,23]. Through an iterative process, broad categories were identified as well as variants and exceptions within the data [24]. Through the process of thematic analysis, the first author individually read each interview transcripts to identify patterns of words or statements that related to the aim of the study and these were placed in broad categories. These results were discussed with the co-authors [22,23]. The broad categories were then analysed in detail to identify subthemes which represented the patterns within the broad categories. Overarching themes were then developed to accurately reflect the findings within the data [24].

Ethics approval was obtained by the University of Western Sydney Human Research Ethics Committee. Pseudonyms are used for the participants throughout this paper to protect their identity.

Results

Twelve women participated in this study, with an average age of 35 years (ranging from 28 to 43 years). Five women were primiparous, seven women had second or subsequent babies. Five of the women were born in Australia, two from the United Kingdom, one from Canada (Table 2).

Eleven women experienced third degree perineal trauma, one woman experienced a fourth degree tear. Two of these women had sustained subsequent third degree tears with one of the women developing a fistula as a result. The length of time that had passed since the participants had sustained SPT ranged from seven week to 12 years. Two of the women gave birth at home, two women had private obstetric care, one woman accessed caseload midwifery care, one woman accessed group midwifery care, and the remaining five women were in the standard public health system where care is generally quite fragmented.

Three main themes were identified: The Abandoned Mother, The Fractured Fairytale and A Completely Different Normal.

The abandoned mother

The Abandoned Mother describes how women feel vulnerable, exposed and disempowered throughout the labour and birth, suturing, and postpartum period and how these feelings are a direct result of the actions of their health care providers. This is further explored in the two subthemes below: Vulnerable and exposed—‘I felt like a piece of meat’, and ‘If only they had told me’.

Vulnerable and exposed—‘I felt like a piece of meat’

During the interview process, women spoke in depth about their labour, birth and postnatal experiences, reflecting upon the support they received and the professionals that provided care for them during this time. For a small number of women, these people were present and supportive and the women described how they felt cared for, informed, and safe. Ten women however described feeling helpless, out of

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<th>Table 2 Demographics of participants</th>
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<td>Aqua</td>
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<td>Sophie</td>
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Average: 35

1.4
control and alone, particularly as they reflected upon the moments immediately following birth as the focus of the midwives and obstetricians in the room transitioned from the woman to the new baby.

I was left lying—I just felt like a piece of meat lying on the bed... they gave her to me—it felt like two seconds—and they took her away and wrapped her all up and they spent more time with her and my husband than what they did with me. He (husband) was all wrapped up and cosying with her up in the nice ward upstairs and I was left... (Scarlet)

As women reflected upon the process of perineal suturing and how they were cared for, they described feeling vulnerable, uncomfortable and exposed on both a physical and emotional level. Such feelings of vulnerability and discomfort appeared to be a result of women's perceptions of the interactions with their care providers. For example, women described how health professionals spoke to and interacted with each other during the labour, birth and suturing process, but rarely communicated directly to the woman herself.

I'm guessing they were midwives, they never actually introduced themselves to me, they just came in and propped my legs up and got the stitch, the needle and thread out, and they had a look, made a couple of attempts and went "the skin just keeps on tearing" and I'll never forget she, the one woman said to the other, she said "Doctor made this mess, she'll have to clean it up herself"). And they left me, they didn't say anything. (Matilda)

I'm kind of insignificant in this whole, you know—I remember these conversations going on around me, I don't remember anyone physically having a conversation with me. (Samantha)

Women were able to clearly recall the facial expressions, actions and words used by the health professionals as they attended to the repair of the perineal trauma.

And [the doctor] didn't really want to talk, she just had this disgusted look on her face when she was doing it. It was horrible ... she could have said "look it's not that bad" or something. There was none of that, she just looked like she was someone who was doing her job and not really enjoying it, like "oh (sighed), I can't believe I have to do this". (Ava)

As they sought to process and cope during the suturing experience, women responded in various ways, including focussing on the newborn, disassociating from the experience using humour in an attempt to engage the health professional and reconnecting to the process, or being present in the moment which was emotionally confronting.

I don’t remember their faces which is weird. Yeah I don’t remember their faces at all. (Matilda)
I don’t know if it was him or the doctor but someone said, man she’s just given birth and she’s just cracking jokes like nobody’s business. I think it was my way of coping as well. (Grace)

"If only they had told me"
The majority of the women who participated in the study reported that they were often not told about the extent of their perineal trauma. The amount of information and education that women reported receiving regarding the perineal trauma they had sustained, potential symptoms that may develop as a result of perineal morbidity, and access to ongoing treatment varied and contributed to their feelings of being abandoned.

I’m really trying to think of what they did on postnatal ward, I’m trying to think when they actually told me it was a third degree tear. Yeah, I don’t think anyone ever volunteered that information. And if they said a third degree I would have said ‘well what’s that?’ you know. Not knowing about the different levels... (Chloe)

The models of maternity care women accessed appeared to influence the amount of information they received and the support they felt they had and this was most evident where women had continuity of care:

...my midwife had been with me the whole time and yep she explained like when it happened that I had torn really badly. And then it was later that day when I was feeling a bit better that my midwife had come back in to check on me as part of the program there and she went through it all with me again, she was really great, she went over it all with me that day." (Sophie)

The fractured fairytale
The Fractured Fairytale explores the disconnect between the expectations and reality of the birth experience and immediate postpartum period for women, and how this reality impacts upon their ability to mother their newborn child and the sexual relationship with their partner. The fairytale of motherhood for many women giving birth is challenged by the reality of nipple pain, postpartum bleeding and sleep deprivation. For women who
have experienced SPT, the reality they face is a stark contrast to the "fairytale".

You have this fairy tale where you have your baby and you take it home and everything’s wonderful and then you go round and show it off to everybody. For me it was an effort. It was like I’m too Uncomfortable I can’t be bothered going anywhere. (Scarlet)

There are four subthemes and these will be explored below: A Broken Body, Achieving a Vaginal Birth, The Contaminated Uncontrolled Body, and They Lived Happily Ever After.

A broken body
Following the birth and the suturing experience, women spoke of the ongoing pain they felt in their perineum. Primiparous women often described the level of pain as unexpected, and they were unsure as to whether or not the pain that they were experiencing was a normal level of pain following a vaginal birth. Multiparous women compared the pain, either negatively or positively, to previous experiences.

I couldn’t go to the toilet. I couldn’t sit in the car. And I basically couldn’t do anything—I was standing up and I was so tired, I could barely even lie down, it hurt that much that I just couldn’t think of anything else. (Matilda)

For both primiparous and multiparous women, the pain was placed in context to the amount of impact it had on what the women were and were not able to do, such as moving independently, passing urine and bowel movements, and breastfeeding their newborn. Some women described how they were unable to perform basic parenting tasks in the first few weeks due to the perineal pain and symptoms associated with SPT.

I mean I couldn’t even sit properly on the lounge. I couldn’t get on the floor and do things with him, like I couldn’t sit on the floor and change a nappy. (Poppy)

Women had an expectation that there would be a full recovery and their body would bounce back to normal, that they would be able to function as a “good” mother and wife. When this did not happen they voiced their surprise at the toll birth took on their body and felt more realistic information needed to be given about this.

I think people need to know that birth isn’t this pretty picture. It isn’t the Home and Away birth of three pushes and you’re out and you’re up and you’re glamorous the next five seconds. (Asha)

Achieving a vaginal birth
Severe perineal trauma is also placed in the context of the birth that they were able to achieve (particularly for women who achieve a vaginal birth after caesarean (VBAC), and the arrival of a well, healthy and happy baby. Vaginal birth appears representative of a woman’s strength and capacity to birth her child, and for some it is a case of “vaginal birth at all costs”. Vaginal birth is for most women part of the fairytale of motherhood and in some ways this compensated them for the feelings of trauma experienced.

And I’m glad I had the experience, I’m glad I had a vaginal birth, I’m glad I didn’t end up in going for a caesarean, I’m glad I birthed him through my own vagina. I can say that even though all of that happened, I did it. And it was horrible in the moment but I can say now that even with all of that I was strong enough. (Matilda)

I guess it was a badge of honour (having a vaginal birth after a caesarean). I had a third degree tear, but I did it. So psychologically that’s how I dealt with it. And I probably, looking back on it now, didn’t give it as much acknowledgement as I should have... cause yeah, I still tried to do everything as I normally would. (Poppy)

The contaminated uncontrolled body
Women described the isolation and embarrassment that came with having what could be described as a contaminated and uncontrolled body. Women often used the word embarrassed to describe how they felt about symptoms that they experienced as a result of SPT, particularly those women experiencing long term urinary and faecal incontinence. Feeling “dirty” and like a “baby with a dirty nappy” resulted in feelings of embarrassment, and in turn impacted upon how they viewed themselves with one woman stating “I just felt hideous”. They felt that there was a stigma associated with incontinence, that “you are dirty and lazy”. The women perceived that it is not culturally appropriate to discuss toileting issues; this lack of discussion resulted in isolation for women as they kept their experiences and symptoms silent. This was the starkest fracturing of the fairytale not only of motherhood but also of womanhood.

Like when you’re a kid if you poo on your pants, there’s this kind of stigma that you’re dirty and lazy. And even when you’re an adult every time it happened I was just like—oh this is filthy, I’m in my twenties and I
can’t control myself. I didn’t want to talk to anybody about it, I didn’t even want to talk to the doctor about it. (Matilda)

Some women described feeling shocked at how basic bodily functions were no longer in their control, such as passing their first bowel movement and unexpected episodes of incontinence. This was compounded by the lack of information and education that the majority of women received and the way it collided with their expectation of what would happen following birth.

I remember when I was being sutured I had wind and I was like oh my god. But I think in that first couple of days maybe once didn’t make it to the toilet—urinary. But I didn’t dare tell anyone because how embarrassing... (Poppy)

Further isolation was described by women as they tried to manage their restricted physical capacity, which occurred as a result of perineal pain, and further as they developed strategies to prepare for unexpected episodes of faecal or urinary incontinence.

Like with (my first baby), despite the postnatal depression I was quite happy to go out and do things, all of a sudden I didn’t go ‘cause it was all a bit too hard. ‘Cause what if (my toddler) falls asleep in the car and I can’t pick him up? So yeah maybe I did feel a bit isolated—’cause I did start to develop postnatal depression when (the baby) was about seven months old... (Poppy)

They lived happily ever after

Every fairytale ends with the line, “And they lived happily ever after”. Implicit in this ending is never ending passion, love and a sexually fulfilling life. For women who have experienced SPT the fairy tale is further fractured by changes in the sexual self and the impact this may have on relationships with their partner. Women describe feeling a sense of fear related to the unknown— for women preparing to have intercourse for the first time following SPT, they are fearful of the pain they may experience, fearful of the changes that have happened and how this may impact on their (and their partners) sexual experience. Some women also describe a fear of getting pregnant again and how that will inevitably result in having to give birth again.

It’s almost like trying to do it for the first time...and I’m almost in tears because I’m so scared. He’s so patient but he does go, maybe tonight we can try and I’m like sure. I was so anxious about it—I made myself really sick. I get migraines and I gave myself a massive migraine—the worst and I was vomiting. How classy is that? I’m like all this because I’m thinking I want to have sex. (Grace)

Women who experience pain as a result of SPT, which is mostly described as being due to friction along the scar tissue (two women described experiencing vaginismus), they either delay intercourse as long as possible, or “put up with it”. Some women describe having to take pain relief medication both before and after intercourse to make the experience bearable.

I used to joke—I used to have to have pain relief to have sex, so you know a couple of panadine, or something stronger if I could find it—neroden plus was good (laughs). Isn’t it terrible? I mean it’s easier now, I don’t usually take it now before, but after. (Poppy)

For some, having intercourse was described as being an important part of their relationship with their partner, for others they described it as fulfilling a commitment, doing their “duty” as a wife and fulfilling their partners sexual needs. They describe that there is an expectation by themselves and their partner that after 6 weeks, they will be “back to normal”.

Six weeks without sex that’s the little magic number you hear, but to still be eighteen months down the track and it’s very rare that we can achieve intercourse... so it certainly has impacted on our relationship because you know he thought things would be back to normal by now. (Sophie)

For women who were experiencing long term symptomatology such as urinary and faecal incontinence, they described feeling a level of anxiety at their unpredictable bodies and how this impacted upon their sexual identity and intimate relationships with their partners. Intercourse was no longer spontaneous due to fear of an unexpected episode of incontinence, and therefore became scheduled around toileting times to ensure cleanliness.

I do remember having sex a few times and going, I really need to go and being actually really worried about it, and wanting to finish it up and then just I have to go the toilet quickly. Going in and going oh phew, thank God nothing happened, nothing came out. (Lola)

The amount of information regarding perineal pain and symptoms that women shared with their partner varied widely. This appeared to be based upon the length of time that they had been with their partner, the severity of their symptoms (the more symptomatic the less
they are likely to share with their partner), and if they have required any ongoing treatment. Women spoke of feeling a sense of concern that their partners would worry about them unnecessarily. The women also wanted to protect the illusion of normality (the fairytale) through this selective sharing of information with their partners.

I think he would probably understand that it’s a sensitive thing. I think that if I had to have surgery I think he’d probably be really sad that I’ve hidden it. Not that I can’t tell him I just don’t really want to right now. Because I’m walking around normally and everything seems quite normal, I don’t think I need to rock that boat. (Lola)

The stark contrast between the expectations and reality for women who have sustained SPT impacts upon both their physical and psychological ability to care for their newborn, their other children, and to fulfil their role as women and wives.

A completely different normal
A Completely Different Normal explores how after women have navigated the treatment pathway maze to try and identify a supportive practitioner/s who can provide an effective treatment option they learn to rediscover and redefine a new sense of self and normality following SPT.

Overwhelmingly, women who experienced long term perineal morbidity and symptomatology described being fearful that any treatment would potentially make their symptoms worse. These women described how they had developed coping strategies over time, embraced a “new kind of normal”, and incorporated these strategies into their daily lives.

I mean at this point I can still cope with it. I’m scared that if they go in there and do something that they might mess it up and make it worse. It doesn’t impact on my life 90 per cent of the time. That other 10 per cent it does, but I can make adjustments to my life to compensate for that. (Lola)

For other women, after seeking multiple treatment and therapies, irrespective of the level of effectiveness of the treatments, women described feeling a sense of resignation and just having to deal with it.

I don’t find it a traumatic thing, now. It’s just what happened. Can’t change it, and really okay I’ve complained about it and figured out well that’s not really doing much and here you go try this tablet, here you go try this cream, but is it just a shit up mechanism? Bandaid affect, that’s how I feel about it. You know what? If these doctors that I’ve spoken to, and they’ve got no answer, then there’s obviously no answer. So deal with it. (Poppy)

Defining a new sense of self
For women who sustained SPT, particularly the women who experienced long term morbidities, in processing their experience they were seen to move towards defining a new sense of self. Women reflected upon their experience of SPT as they attempted to understand and normalise the experience. This process appeared to be influenced by the length of time that had passed since the woman had given birth, the level of morbidity that the woman experienced, and the care that they had received. For some women, their experience of pregnancy, labour, birth and the postpartum was one intertwined, complex process, with each element of the journey impacting upon the other. For other women however, their recollection of sustaining SPT and their postpartum experience was understood as a separate experience to that of the pregnancy, labour and birth.

Because I’ve kind of compartmentalised that point in my life as my experience of birth. I’m just of the opinion that you just have to draw a line in the sand sometimes and just say I can choose to look at it negatively or I can choose to look at it positively and see what came out of it. (Matilda)

As women came to grips with their different kind of normal, they learnt to adapt their lifestyle. They realised things should have been different but reached a kind of acceptance. This was seen more with women who had sustained SPT several years ago.

Time went on and I just kind of changed a few things, like stopped wearing G-strings and carried wipes and spare undies around. I just adapted my lifestyle to it. (Lola)

Women attempted to justify their experience by talking about the physiology of the birth process. For some they blame themselves using the words “I’m not stretchy” or “I could have done more”, while others blamed the system, saying “I felt let down”.

No I don’t think that my body has let me down. I think it’s just happened. I think it’s probably just bad luck and these things happen. My babies were not that big. It’s a pretty small hole. I’m not surprised. (Lola)

Some women spoke of how they worked to reconcile the birth that they had hoped for with the reality of their
birthing and postnatal experience, and this required a period of processing which led to a resigned acceptance.

... because in a heartbeat I'd do it all again, because she's my world, but yeah I guess it does make me really sort of upset, I felt I did everything right, but then my body didn't follow through with what should happen. (Sophie)

I don't think I'm as confident probably in certain areas. Like I'm always aware of it. I never forget about it. It gets me down sometimes. I just think why can't everything have just gone normally and healed up. Then on the other hand at least I'm not leaking all the time. It sucks. (Lola)

For women who were able to access a supportive group, meeting women with similar experiences facilitated an opportunity to compare, share strategies and experiences, providing women with a way to comprehend and move towards a "new kind of normal".

Discussion
The findings from this research have highlighted the complex physical and psychosocial impact, and the difficulties faced by women who experience SPT during vaginal birth. While current literature focuses on the morbidities that women experience as a result of SPT, the women in this study focused not only on the morbidities but also on how they were treated during the birth, the suturing process and the postpartum period. The model of care, levels of compassion and companionship that women did or did not feel during labour and birth impacted on how they reflected upon, and dealt with, their experience of SPT. Their experience with care providers contributed towards and reinforced the way women viewed their postpartum body as disembodied and disconnected. Limitations of this study included the small number of women that were interviewed in New South Wales only, and that these women were all self-selected, which may represent a limited view. The use of word of mouth and snowball sampling to recruit participants may have resulted in recruitment of women with similar experiences, therefore methods of participant recruitment should be considered for future qualitative studies. Another limitation is that as an insider of the group being researched, it was important that the researcher had an awareness of their place within the research and the potential impact this had upon the interaction with study participants and interpretation of data [25,30]. The use of reflexivity ensured objectivity and authenticity throughout the research process. To further ensure objectivity the interview transcripts, broad categories, subthemes and themes were reviewed and discussed with the co-authors.

Disembodied and disconnected
The women in this study vividly recalled the moment of birth, and the time when they became aware of the damage that had occurred to their perineum following the birth of their baby. They were overwhelmed by the birthing experience and the moment that they met the newborn child, but they were yet to understand the implications of the trauma that they had sustained to their perineum. The transition from self to other—where other is an unknown and unfamiliar self—and the alteration, or for some women, the distortion of body boundaries that occurred in pregnancy, reaches a pinnacle during the birth process [12,13]. At the moment of birth a woman experiences a physical and emotional opening of the self to the other, and the loss of the boundary of what is internal and external occurs as the baby and placenta are born, accompanied by blood and other fluids. While Young [12] suggests that the act of childbirth is a "conclusion", at which time women undergo a transition to a new self, for women who sustain SPT there is a continuation of this physical trauma associated with birth through the perineum, extending and distorting the boundaries of the known body [12,13]. For some women who experience ongoing urinary, flatus and/or faecal leakage, it may be that closure or sealing of the boundary between the internal and external body is never fully achieved as explored in the subtheme The contaminated/uncontrolled body. This creates a contradiction for women who have experienced SPT. Their known body boundaries are permanently altered, yet they seek physical and emotional closure. The disconnected and disembodied sense of self presents multiple challenges to the woman after birth, and this disconnection is in part produced and reproduced by the actions and interactions with health professionals during the time of birth and in the immediate postpartum period [12,27].

It has been argued that existing maternity care is influenced by the works of Descartes (1993) and Cartesian dualism as discussed by Goldberg [28], whereby the mind and body are seen as distinct from each other, the body is seen as an object functioning as separate systems or parts [29,30]. In contrast to the Cartesian dualistic perspective, the work of philosophers such as Merleau-Ponty suggests that the mind and body is in fact a "unified whole", the body is described as being unique to the individual and anchors the person to their being in the world, using the term 'the lived body' [31]. While the writings of Merleau-Ponty have been criticised by feminist scholars as ignoring the concept of gendered subjectivity [9,29,32], it can be argued that the traditional Cartesian view maintains an objectification of the function of the perineum by health professionals, therefore dismissing the psychological impact on women as they
face pain and ongoing morbidity following SPT. Women in this study struggled to retain their known lived body through the physical and emotional barriers that they experienced as a result of trauma they sustained to their perineum. The women further reported that following the birth the focus of the health professional was on the wellbeing of the newborn baby as described in the theme The Abandoned Mother and sub-theme If only they had told me, and as a result women described feeling like “a piece of meat” with this perspective further reinforcing the dualism and loss of self that women are experiencing.

The leaking uncontrolled body

Based upon the writings of Menkes-Ponty and the concept of the lived body, it has been suggested that any change to this known self, for example through trauma or illness, can present challenges for the individual in understanding their altered body [33,34]. Literature exploring the impact of disability (physical or intellectual) on the perception of self has described how a separation, or dualism, occurs between the mind and body as the functioning and/or appearance of the disabled body part becomes objectified by the individual as it is unfamiliar and unknown [31,35,56]. This phenomenon was seen during the interviews with the women as explored in the sub-theme A broken body, who used the terms ‘it’ and ‘thing’ when they referred to their perineum. Such changes can be seen to occur following childbirth, as stated by Young: “The perineum is other, as it no longer functions as it should, however it is attached to me and therefore is mine...” [12], p.50.

Drawing on the work of Kristeva, women who sustain SPT and continue to leak urine and/or faeces may experience abjection, whereby bodily leakage and the altered perineum (described as the abject) contrasts with the cleanliness of the contained pre-pregnant body (non-abject), therefore women will work to protect themselves from the threat that the abject presents to their known self (abjection) [10,37]. As stated by Kristeva: “It is thus not the lack of cleanliness or health that causes abjection, but what disturbs identity, system, order.” [10], p.4. Based upon these understandings the negative societal constructs around the leakage of bodily fluids can be seen to add to the abjection that women may experience.

Feminist work exploring constructions of contemporary bodies suggests that a well-managed, contained and controlled body is presented as mature and masculine, and is a stark contrast to the altered, leaking postnatal body that appears uncontrolled and immature [29,38]. The language used by the women in this study reflected this link between uncontrolled bodily functions and immaturity, by referring to faecal incontinence as being dirty like a ‘toddlers’ or a ‘baby’. Similar findings have been reported by Peake et al. who distributed a questionnaire to Australian women who were experiencing urinary incontinence. These women associated leaking urine, and their inability to control episodes of urinary incontinence, with the stereotype of the ‘naughty child’ [39]. Danaher et al. drawing on the work of Foucault suggest that individuals are classified based upon cultural rules, discourses and expectations based upon gender and related bodily functions [40]. For women who are experiencing ongoing urinary or faecal incontinence as a result of SPT, there appears to be a cultural consensus that leaking, messy and ‘dirty’ bodies must be naged and hidden [41-43]. Furthermore, Foucault described self-surveillance as a practice that individuals use to control that which may be perceived as dysfunctional by society to maintain a sense of normality, as technologies of self [40]. The women in this study reported how they made adjustments to their daily living activities to control or minimise unexpected episodes of incontinence to accommodate their unpredictable perineum, as explored in the theme A Complete Different Normal. Reflecting upon Kristeva’s concept of abjection, research conducted by Thomas-MacLean examining women’s experiences following mastectomy, found that the women were hesitant to show their scarring to their husbands as a way of protecting their partners from abjection [44]. This reflects the actions of the women in this study who were often reluctant to share information with their partners regarding perineal pain or incontinence so as to protect the partner from experiencing distress and concern, and maintain an appearance of normality [44].

Sexuality and relationships

Literature has described the impact that childbirth and associated outcomes including breastfeeding, exhaustion and SPT, can have on the sexual relationship between a woman and her partner and this was a major concern for the majority of the women who participated in this study [9,45-47]. As examined in the sub-theme They lived happily ever after, women described feeling anxious and feared potential pain they may experience, and due to the unpredictable nature of their bodies, were fearful of unexpected episodes of incontinence which impacted upon their ability to engage in spontaneous acts of sexual activity. Similar findings have been reported, suggesting that this level of anxiety and fear impacts not only upon the sexual relationships women engage in with their partners, but their sexual identities as women and wives [9,46,48]. A study conducted by Hipp et al. suggests that following childbirth women are conscious of the needs of their male partners, therefore irrespective of the physical and psychological impact of perineal trauma, women initiate the resumption of sexual activities to fulfill these expectations [49]. Despite this it has been reported that
for women experiencing perineal pain and dyspareunia following vaginal birth, there may be a delay in the re-
sumption of intercourse [47,50]. In reflecting upon the
differences that occur to the pregnant body, Young describes
how awareness may be drawn to a part of the body (such
as the pregnant abdomen) due to the uncomfortable
sensations or restrictive nature of this object [12]. Simi-
larly, this experience may occur for women who have
experienced SPT; they are made aware of the object (the
perineum) due to unfamiliar sensations, discomfort or
pain due to tenderness and scar tissue, and this may also
lead to fear. This awareness may result in women focus-
ing on the object, and therefore unable to enjoy the mo-
ment during the act of sexual activity.

The paradox
The women in this study described feeling surprised and
upset when the reality of childbirth and the postnatal
period did not match their expectations, resulting in a
"fractured fairytale", however despite this they were grate-
ful to have experienced a vaginal birth. Boon suggests that
motherhood is shaped upon social and cultural expecta-
tions, whereby when maternal morbidity does occur there
is an expectation that it will be accepted as part of the
birth process, and that "The glory of motherhood and
the wonder of new life compensating, somehow, for per-

For the majority of women who participated in this
study, particularly the primiparous women and the woman
who had achieved a vaginal birth after caesarean (VBAC),
they reflected positively upon their experience of labour
and vaginal birth, describing the experience as "empower-
ing" and "beautiful" as described in sub theme Achieving a
vaginal birth. It seemed paradoxical that women gave
accounts of their pleasure of giving birth vaginally, the act
that had resulted in their physical trauma, and the emo-
tional distress and how they felt they were treated, and
that they were somehow able to resolve this. There is
evidence to suggest that women identify a strong link
between vaginal birth, femininity and womanhood, this
link is apparent in literature examining birth after trauma
and VBAC [46,52-54]. Studies have shown that
women report the benefits of vaginal birth as enabling
bonding with their newborn infant and assisting in estab-
ishing breastfeeding; this is reported as being of particular
importance to women who are planning a vaginal birth
after caesarean [9,53].

The disconnect between the expectations and reality
of labour, birth and parenthood may have psychological
implications for women leading to feelings of guilt, anxiety
and a sense of loss, which may lead to the development of
postnatal depression [55,56]. Literature exploring mother-
ing describes how despite the physical and psychological
challenges faced by women there is an expectation by
society, and the women themselves, that maternal tasks
will be completed by the new mother, and consequently
an inability to complete these tasks may impact upon the
emotional wellbeing of new mothers [54,57]. Such feelings
are reported particularly by women who experience phys-
ical trauma during the birthing experience, or have an un-
expected birthing outcome, including instrumental birth,
caesarean section and postpartum haemorrhage [54,58].
Rubin’s work on the transition to motherhood describes the
impact that body image has upon this time of transi-
tion, that the new functional body is representative of the
successful transition of the woman to the maternal role
[59]. The author describes that for women who experience
a postnatal body that is unable to be controlled may ex-
perience depression, poor self-esteem and “risk of role
failure”, and this resonates with the words of the women
in this study [59], p. 240.

Conclusion
The findings of this study describe and explain the experi-
ences for women who have sustained SPT during vaginal
birth. The three main themes identified that how women
are cared for during their labour, birth and postnatal
period has a direct impact on how they understand and
rediscover a new sense of self following SPT. The findings
indicate that further research is required into the experi-
ences of women with SPT in accessing appropriate health
management services in the immediate postnatal period.
An evaluation of current services for women who ex-
perience ongoing physical morbidities is also important.
Recommendations for future practice include the estab-
ishment of specialised perineal care clinics that give
consistent and collaborative care for women [46,60].

Competing interests
The authors declare they have no competing interests.

Authors' contributions
HP participated in research design, data collection and analysis, design and
drafting of manuscript as a component of a doctoral study. JS assisted with
review of data and manuscript drafts. HD assisted with data collection;
review of the data and manuscript drafts. All authors read and approved the
final manuscript.

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5.2 Chapter Conclusion

This chapter has reported the findings from interviews with women as published in the paper titled, ‘Women’s experiences following severe perineal trauma: a qualitative study’. This paper described women’s experiences of SPT and how this experience has impacted upon their physical and emotional wellbeing. Details of women’s interactions with health care providers during their birth, suturing process, and postpartum period are also described. The following chapter presents the published findings of Stage 3 of the study, a discussion group and survey conducted with the Clinical Midwifery Consultants (CMCs) from each Local Health District (LHD) in NSW.
Chapter Six: “A patchwork of services” – caring for women who sustain severe perineal trauma in New South Wales – from the perspective of women and midwives.

6.1 Publication relevance to thesis


This paper presents the findings of a discussion group and survey conducted with the Clinical Midwifery Consultants (CMCs) of NSW. One overarching theme was identified: ‘A Patchwork of Policy and Process’. Four subthemes were identified: ‘Falling through the gaps’; ‘Qualifications, skills and attitudes of health professionals’; ‘Caring for women who have sustained SPT’; and ‘Gold standard care: how would it look?’.
"A patchwork of services" – caring for women who sustain severe perineal trauma in New South Wales – from the perspective of women and midwives

Holly S Priddis, Virginia Schmied, Christine Kettle, Anne Sneddon and Hannah G Dahlen

Abstract

Background: Current research into severe perineal trauma (3rd and 4th degree) focuses upon identification of risk factors, preventative practices and methods of repair, with little focus on women’s experiences of, and interactions with, health professionals following severe perineal trauma (SPT). The aim of this study is to describe current health services provided to women in New South Wales (NSW) who have experienced SPT from the perspective of Clinical Midwifery Consultants (CMC) and women.

Methods: This study used a descriptive qualitative design and reports on the findings of a component of a larger mixed methods study. Data were collected through a semi-structured discussion group using a variety of non-directive, open-ended questions leading CMCs of NSW. A survey was distributed prior to the discussion group to collect further information and enable a more comprehensive understanding of services provided. Data from individual interviews with twelve women who had experienced SPT during vaginal birth is used to provide greater insight into their interactions with, and ease of access to, health service providers in NSW. An integrative approach was undertaken in reporting the findings which involved comparing and analysing findings from the three sets of data.

Results: One overarching theme was identified: A Patchwork of Policy and Process which identified that current health services operate in a ‘patchwork’ manner when caring for women who sustain SPT. They are characterised by lack of consistency in practice and standardisation of care. Within the overarching theme, four subthemes were identified: Falling through the gaps; Qualifications, skills and attitudes of health professionals; Caring for women who have sustained SPT; and Gold standard care: how would it look?

Conclusion: The findings from this study suggest that current health services in NSW represent a ‘patchwork’ of service provision for women who have sustained SPT. It appeared that women seek compassionate and supportive care based upon a clear exchange of information, and this should be considered when reflecting upon health service design. This study highlights the benefits of establishing multi-disciplinary collaborative specialist clinics to support women who experience SPT and associated morbidity with the aim of providing comprehensive physiological and psychological support.

Keywords: Qualitative research, Severe perineal trauma, Health services, Birth
Background
During vaginal birth, approximately two thirds of Australian women will experience some degree of trauma to the perineum [1]. Perineal trauma is defined by the extent of injury sustained to the perineum, skin, perineal muscles, labia, clitoris, urethra and anal sphincter. It is estimated that approximately 1.8% will experience severe perineal trauma (SPT), which is defined as a third or fourth degree tear to the perineum and anal sphincter complex [Table 1], and may result in both short and long term physical and emotional morbidities for women [2,3].

A comparison of data reporting upon the incidence of SPT in New South Wales (NSW) from 2000–2008 found a significant increase in the overall rate of SPT from 3.9% to 19.8% [4]. This increase was particularly seen in third degree tears and extensions following episiotomies [4]. Internationally, the incidence of SPT is reported to range from between 0.5 – 7%. This variation may be due to the reporting process, obstetric management, and differences in the definition of perineal trauma [5-7].

Current research into SPT focuses upon the identification of risk factors, preventative practices and the most appropriate methods of repair, with little focus on women’s experiences of, and interactions with, health professionals following SPT [8-10]. In Australia, care provided to women in the first week following childbirth is most often provided by a midwife either in hospital or in the community during home visits. For women who are cared for within the private model, postnatal support is provided by an obstetrician. The average duration of care is two to ten days postnatal, however some models of maternity care provide support up to six weeks following the birth [11].

Women have reported variation in information received regarding the degree of perineal trauma they sustained, and the symptoms that may develop varied, contributing to feelings of vulnerability and abandonment [8]. Access to specialist postnatal care may be beneficial for women’s long term physical and psychological wellbeing, however current health services do not appear to provide adequate support nor address the physical and psychological needs of women [12]. The actions of health care providers, and how they interact with women during the time of birth, has an impact upon how women understand and experience SPT and at times these interactions have been reported as being insensitive and inappropriate [9,13]. Previous research indicates that women can feel vulnerable, exposed and abandoned throughout the labour and birth and suturing process, and that these feelings may be influenced by the actions of health care providers [8]. Research reporting on the experiences of health care providers caring for women who sustain SPT, focuses upon their ability to identify and repair perineal trauma, and the psychological impact of caring for a woman who sustains a childbirth related injury [14,15]. However, there appears to be a lack of literature describing the structure of health service provision for women who sustains SPT and related co-morbidities from the perspective of clinical leaders.

The aim of this study is to describe current health service in NSW provided to women with SPT from the perspective of Clinical Midwifery Consultants and women.

Method
This study used a descriptive qualitative design [16-18]. Data were collected through a discussion group with the Clinical Midwifery Consultants (CMCs) of NSW. Data from individual interviews with women who had sustained SPT is used to provide greater insight into their interactions with, and ease of access to, health service providers in NSW.

This paper reports on the findings of a component of a larger mixed methods study which included four phases: A meta-ethnographic study examining the experiences for women who had sustained a postpartum physical morbidity including SPT [8]; a linked data study which reported upon the risk of recurrence, subsequent mode of birth and morbidity for women who experienced SPT in NSW between June 2000 and July 2008 [19]; In-depth interviews to explore the experiences of women who had sustained SPT [12]; and a discussion group and survey conducted with the Clinical Midwifery Consultants of NSW which is reported on in this paper and integrated with relevant data quotes from interviews with women related to interactions with, and service provision from, health care providers which were not published in the previous study.

Participants and recruitment
Fourteen CMCs participated in this study. All CMCs were experienced midwives currently practising in NSW and in their role as a consultant they are responsible for writing policy, supporting best practice, and providing midwifery leadership across the state. They are ideally positioned within their roles to have a comprehensive view of how the service works and where the strengths

Table 1 Definition of perineal trauma [2]

<table>
<thead>
<tr>
<th>Degree</th>
<th>Trauma to Perineum</th>
</tr>
</thead>
<tbody>
<tr>
<td>First degree</td>
<td>Laceration of vaginal epithelium or perineal skin</td>
</tr>
<tr>
<td>Second degree</td>
<td>Involvement of perineal muscles, not anal sphincter</td>
</tr>
<tr>
<td>Third degree</td>
<td>Disruption of anal sphincter muscles –</td>
</tr>
<tr>
<td>3a</td>
<td>&lt;50% external sphincter torn</td>
</tr>
<tr>
<td>3b</td>
<td>&gt;50% external sphincter torn</td>
</tr>
<tr>
<td>3c</td>
<td>External and internal sphincter torn</td>
</tr>
<tr>
<td>Fourth degree</td>
<td>Third degree tear with rupture of trauma to anal epithelium</td>
</tr>
</tbody>
</table>
and weaknesses lie. This group of CMCs meet quarterly at a Sydney location.

Twelve women who had sustained SPT were interviewed for this study, the recruitment and participation process has been previously published [12]. Data not published in the previous study in relation to service provision for SPT is used in this study to contrast or support the CMCs comments.

To ensure informed consent for both the participants of the discussion group and the women who were interviewed, participation was self-determined in response to an information sheet distributed via email which provided full disclosure of the research currently being undertaken. Each woman contacted the researcher enquiring about the research who met the criteria for recruitment was provided with the information sheet. Participants were given the contact details of the researcher to ask any questions prior to giving consent. Participants were then asked to read and sign the consent form if they agreed to participate. Both the women and the CMCs were assured of confidentiality and advised that all data would be de-identified during transcription of the recording to protect identities. It was further clarified that participation was optional, that participants were able to request that digital recordings cease immediately at any time during the discussion group session, and were given the opportunity of withdrawing from participation at any time without penalty [20].

Data collection
Discussion group with the CMCs
The purpose of the discussion group was to develop an understanding of current health services provisions in NSW for women who sustain SPT as reported by currently practicing CMCs working within the NSW Health system. The discussion group was one hour in duration, recorded with permission via signed consent using a digital voice recorder, and was transcribed verbatim by an external transcription company. The discussion group was facilitated by the first and last authors and was semi-structured, using a variety of non-directive open-ended questions which were used as triggers to stimulate conversation regarding the topic at hand (Hammersley & Atkinson, 2007).

Survey of CMCs
Due to the size of the group and the limited time frame allocated (one hour) this did not lend itself to the level of interaction possible in a smaller discussion group [21,22]. Therefore a survey, containing nine multiple choice questions and one short answer response, was distributed to all participants to collect further information and enable a more comprehensive understanding of the services provided in NSW (Tables 2 and 3). The questions for the discussion group and survey were designed in response to the overarching themes and findings that were identified in previously conducted research which has been reported [12,19].

Interviews with women
In addition, data were collected in face to face interviews with twelve women who had experienced SPT following vaginal birth. The purpose of the interviews was to explore the way women experienced and understood SPT, and their interactions and experiences with health professionals and health services. Each interview was between one to two hours duration and was semi-structured, using open ended questions [23]. The methods used for these interviews have been fully described in a previous paper [12]. Pseudonyms are used for the participants throughout this paper to protect their identity.

Data analysis
An integrative approach has been used in reporting the findings which has involved comparing and analysing the findings from the three sets of data [24]. Integration was undertaken with the aim of facilitating a greater understanding of the topic under investigation [24,25]. Initially, the analysis of both datasets from the CMC discussion group and the interviews with women were conducted separately using thematic analysis. Through the process of thematic analysis, the first author individually read the transcript from both the interviews and the discussion group to identify patterns, of words or statements, that related to the focus of the study [26]. These groups were then placed in broad categories, and these results were discussed with the co-authors [27]. The broad categories were then analysed in detail to identify subthemes or key concepts which represented the patterns within the broad categories. Overarching themes were then developed to accurately reflect the findings within the data [12,26].

The survey responses were recorded and compared with the themes identified from the CMC discussion group, with similarities and disparities noted. The priority data set represented in this paper are the themes which were identified following the discussion group with the CMCs, the words of the women have been incorporated to provide added depth to the main themes. The focus of discussion with the CMCs was not always represented in conversations with the women and therefore there was no comparative data to include. During comparative analysis, the major themes and subthemes arising from the two separate datasets were analysed and compared to determine similarities and differences. The themes that overlapped or were common to both data sets were then integrated to undertake a second level of analysis. Through this process common themes were
Table 2 CMCs responses to survey questions

<table>
<thead>
<tr>
<th>Questions asked in survey of CMCs</th>
<th>Responses (number)</th>
</tr>
</thead>
<tbody>
<tr>
<td>In what location are the majority of third degree perineal tears repaired?</td>
<td></td>
</tr>
<tr>
<td>a. Birthing room</td>
<td>8</td>
</tr>
<tr>
<td>b. Theatre</td>
<td>5</td>
</tr>
<tr>
<td>c. Other</td>
<td>1</td>
</tr>
<tr>
<td>(3 respondents included two locations in their response)</td>
<td></td>
</tr>
<tr>
<td>In what location are the majority of fourth degree perineal tears repaired?</td>
<td></td>
</tr>
<tr>
<td>a. Birthing room</td>
<td>2</td>
</tr>
<tr>
<td>b. Theatre</td>
<td>11</td>
</tr>
<tr>
<td>c. Other</td>
<td>1</td>
</tr>
<tr>
<td>What suture material is predominantly used for severe perineal trauma repairs?</td>
<td></td>
</tr>
<tr>
<td>a. Vinyl</td>
<td>8</td>
</tr>
<tr>
<td>b. Dexon</td>
<td>3</td>
</tr>
<tr>
<td>c. Catgut</td>
<td>3</td>
</tr>
<tr>
<td>d. Polynor</td>
<td>0</td>
</tr>
<tr>
<td>e. Other</td>
<td>0</td>
</tr>
<tr>
<td>(one respondent answered with Figure Eight)</td>
<td></td>
</tr>
<tr>
<td>Who is permitted to repair severe perineal trauma?</td>
<td></td>
</tr>
<tr>
<td>a. Midwives</td>
<td>1</td>
</tr>
<tr>
<td>b. Paediatricists</td>
<td>9</td>
</tr>
<tr>
<td>c. Registrars</td>
<td>3</td>
</tr>
<tr>
<td>d. Other</td>
<td>0</td>
</tr>
<tr>
<td>(6 respondents included two health professionals in their response)</td>
<td></td>
</tr>
<tr>
<td>When severe perineal trauma occurs is it a reportable incident?</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>12</td>
</tr>
<tr>
<td>No</td>
<td>1</td>
</tr>
<tr>
<td>Sometimes</td>
<td>1</td>
</tr>
<tr>
<td>Is there a follow up clinic available that women are referred to?</td>
<td></td>
</tr>
<tr>
<td>a. Yes</td>
<td>10</td>
</tr>
<tr>
<td>b. No</td>
<td>3</td>
</tr>
<tr>
<td>(one respondent answered with “unsure”)</td>
<td></td>
</tr>
</tbody>
</table>

Table 2 CMCs responses to survey questions (Continued)

| Has a recent audit been undertaken on the incidence of severe perineal trauma within your area/unit? |                      |
| a. Yes                                       | 10                  |
| b. No                                        | 3                  |
| (one respondent answered with “unsure”)      |                     |
| Do you think the incidence of third and/or fourth degree perineal trauma is rising? |           |
| a. Yes                                       | 10                 |
| b. No                                        | 2                  |
| c. Unsure                                    | 2                  |

identified which enabled an understanding of how health services in NSW care for women who sustain SPT from the perspective of women and CMCs.

Ethics approval was obtained by the University of Western Sydney Human Research Ethics Committee, approval number H9298.

Results

Participant demographics

The CMC participants represented both regional and rural local health districts (LHD), and individual hospitals and maternity services, across NSW. At the time of this research there were 16 LHD’s in NSW, all but one LHD was represented in this discussion group. All CMCs who participated were female, with an average age of 52 years (Table 4).

Table 3 Survey question 10: Rank in order from 1 to 10 (1 being most significant, 10 being least significant) what you feel contributes to the incidence of severe perineal trauma

<table>
<thead>
<tr>
<th>Item</th>
<th>Average score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Position for second stage</td>
<td>2.08</td>
</tr>
<tr>
<td>Instrumental birth</td>
<td>3.38</td>
</tr>
<tr>
<td>Episiotomy</td>
<td>3.46</td>
</tr>
<tr>
<td>Foetal</td>
<td>5.81</td>
</tr>
<tr>
<td>Hands off technique</td>
<td>6.1</td>
</tr>
<tr>
<td>Ethnicity of woman</td>
<td>6.25</td>
</tr>
<tr>
<td>Position for labour</td>
<td>6.36</td>
</tr>
<tr>
<td>Model of care</td>
<td>6.36</td>
</tr>
<tr>
<td>Epidural</td>
<td>6.54</td>
</tr>
<tr>
<td>Maternal weight</td>
<td>7.36</td>
</tr>
<tr>
<td>Maternal age</td>
<td>7.72</td>
</tr>
<tr>
<td>Gender of baby</td>
<td>10</td>
</tr>
</tbody>
</table>
Table 4 CMC demographics

<table>
<thead>
<tr>
<th>CMCs</th>
<th>Demographics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total participants</td>
<td>14</td>
</tr>
<tr>
<td>Average age in years</td>
<td>52.07 years</td>
</tr>
<tr>
<td>Average years of practice</td>
<td>30.8 years</td>
</tr>
<tr>
<td>Average years in current role</td>
<td>11.8 years</td>
</tr>
<tr>
<td>Australian born</td>
<td>9</td>
</tr>
<tr>
<td>Aboriginal or Torres Strait Islander</td>
<td>0</td>
</tr>
<tr>
<td>Other</td>
<td>5</td>
</tr>
</tbody>
</table>

The demographics for the women who participated in this study are presented in Table 5.

Themes and subthemes

One overarching theme was identified following the process of comparative analysis: A patchwork of policy and process. Within the overarching theme, four subthemes were identified: Failing through the gaps; Qualifications, skills and attitudes of health professionals; Caring for women who have sustained SPT; and Gold standard care: how would it look? (Figure 1).

Overarching theme: a patchwork of policy and process

The overarching theme that emerged from the discussion group was that health services in NSW operate within a patchwork of policy and processes when providing care for women who sustain SPT. The CMC participants reported that currently there is little consistency or standardisation of protocols, policies or guidelines across NSW to guide the treatment or follow up care for women who had sustained SPT during birth.

There was a discussion at a high risk meeting with the medical officers about where severe perineal trauma should be repaired and who should do what. There was no agreement whatsoever with them, nothing. Everybody does different things. (CMC)

CMCs believed that care for women who have experienced SPT varies and this variation ranges from local district policies and protocols to individual practitioner preferences on how immediate repair and long term care should occur. This was reported by participants from both metropolitan and rural LHD’s: “There’s not consistency. It’s more practitioner driven...”. The preferences of the individual medical practitioners were described as impacting upon the implementation of guidelines and policies. For example, it was reported that for one LHD a district wide policy existed in draft form, however this policy was unable to be progressed due to an inability to gain consensus from the area’s representative medical staff as to appropriate care guidelines.

Similarly, women described the challenges they faced in attempting to navigate treatment pathways, often reporting that the lack of identifiable and available services were inadequate in meeting their needs.

I felt like I didn’t have enough support, but I didn’t really know where to go to get it. I didn’t really know whether it actually existed. I just wished somebody would have just said, go to the GP. If there’s a problem, go and do something about it. (Indie)

Some CMCs however described how a coherent policy guided how health professional provided care for women who had sustained SPT within their health service.

We have a policy. There is a policy in place and there is a pro forma that the midwives and doctors have to complete. (CMC)

Qualifications, skills, beliefs, and attitudes

Qualifications and skills

The CMCs described the level of skill and credentialing process required for health professionals to undertake repair of SPT to be inconsistent and unclear. In response to the survey question “Who is permitted to repair severe perineal trauma?”, participants indicated that the necessary qualifications to undertake repair ranged from resident medical officers RMO to
specialist colorectal surgeons (Table 2). In individual health facilities where a credentialing process was reported to exist, the CMCs were mostly unclear on what this process involved. It was reported that one tertiary level maternity unit had a clear credentialing process in place, whereby repairs were able to be conducted only by an obstetric and gynaecology (O&G) registrar in their third year of practice, a staff specialist or above. Some services had commenced a mentorship program for RMOs, however it was unclear what qualifications the mentor was required to have. Some facilities had no credentialing process at all:

There’s no level of credentialing for the registrars. I guess it’s left up to their individual level, just like the midwives are – “I don’t want to do this repair because it looks too big”. I’m hoping that’s what’s happening there. (CMC)

The CMC participants also expressed concern over inconsistencies around training staff to undertake a comprehensive perineal assessment following a vaginal birth. It was reported that junior staff or health professionals without current perineal assessment skills, may incorrectly diagnose the grade of perineal trauma, this may result in an inadequate repair being performed:

If the midwife is in there and she doesn’t recognise that it’s a third degree tear, that’s not going to get picked up... she’s not going to get anybody in there to do it. (CMC)

The participants discussed the roles that registrars, obstetricians and colorectal surgeons played in SPT repair. Some participants described a conflict that existed between the role and responsibilities of the registrar and colorectal surgeon: “...because there are obstetricians or VMOs [Visiting Medical Officers] that get upset when the registrar calls in the colorectal surgeon.”

In contrast, other services described a collaborative process that had been established between the obstetricians, registrars and colorectal surgeons in identifying and repairing SPT but they were in the minority:

If they’re anything more than a 3A tear, then they [registrars] notify the colorectal surgeon. The colorectal surgeon is actually in theatre when they initially assess the tear, prior to deciding whether it’s worse than a 3B or whether it’s a fourth. They actually work together. It’s a really, really good collaborative agreement. (CMC)

Within some LHDs the CMC representatives reported a concern at the lack of diagnostic facilities and therefore the accuracy of perineal assessment:

I’ve heard a colorectal surgeon talk about his “magic finger”. They don’t have manometry in hospital. They don’t have pudendal nerve testing and they don’t have endoanal scans specifically for women. So they’re not really assessing it properly at all. (CMC)

Some of the CMC participants believed that the inconsistencies in assessment, evaluation and repair were a result of perineal trauma not being seen as an obstetric priority and therefore standardisation of care

Figure 1 One diagrammatic representation of themes.
and training was not seen as important: “There’s very little clinical review of particular cases. It’s not seen as something that they need to review. I think that needs a discussion as well.” (CMC)

In response to this, one service that conducted an audit and identified incorrect diagnosis contributing to increasing SPT statistics, introduced a policy stating that two health professionals were now required to review each woman with perineal trauma (second degree tear or above), to increase the likelihood of correct identification and repair.

Beliefs about the cause of SPT
In both the survey responses and the discussion, the majority of CMC participants indicated that they believed the incidence of third and fourth degree perineal trauma was increasing, and in response to this participants indicated that at a number of health facilities internal audits had been undertaken to identify the reasons for increased reporting (Table 2). On the survey, CMCs were asked to rank in order from 1 to 10 what they believed was the most significant contributor to the incidence of SPT, with position for second stage being highlighted as the most significant cause, followed by instrumental birth and episiotomy (Table 3).

Many of the women who participated in the interviews spoke of strategies they used, or had heard of, during the antenatal period, to minimise the risks of sustaining perineal trauma. These strategies included the use of oils and massaging their perineum to make the area more flexible for birthing, while one participant described using a device to stretch the perineum. Women reflected on these strategies, often describing that they had let themselves tear by forgetting or neglecting to perform perineal massage consistently during their pregnancy which resulted in them sustaining SPT. Other women stated the perineal trauma was due to a defect in their anatomy: “I just wasn’t stretchy enough and that’s why I tore.” (Asha). Further, women described that they felt incorrect pushing techniques, the use of instruments during the birth, and a rapid birth contributed to perineal trauma.

The attitudes of health professionals
For women who have sustained SPT, they were less concerned about the method of perineal repair that was performed, and more concerned with how they were cared for during this time. During the suturing process, the women recall clearly the facial expressions, words and phrases that the midwives and obstetricians used during the suturing process. The women interviewed described how staff spoke “around them” and “about them”, often not speaking directly to the women, and this resulted in women feeling vulnerable and exposed during the procedure.

I got embarrassed at one point, I’m just thinking I can’t believe I’m just lying here like this and they’re having a little discussion about what’s going on. They didn’t discuss it with me at all. Maybe they just thought I wasn’t worth it. But maybe they think well they don’t understand it anyway so what’s the point? (Scarlett)

Falling through the gaps
The participants described that the care that women received in both the immediate and long term postnatal period varied amongst LHBD’s and individual practitioners. The majority of services provided information leaflets outlining perineal care to women prior to discharge. In response to the survey question: “Is there a follow up clinic available that women are referred to?”, ten participants responded with ‘yes’, three with ‘no’, and one participant was ‘unsure’. Some of the services offered a range of counselling services for women who had sustained SPT, other services reported that there were no routine postnatal support pathways in place.

The referral process for women to access follow up anal sphincter assessment was also seen to be practitioner dependent. “So someone like a specialist obstetrician may keep the women to review himself and, maybe, other areas where there’s GP obstetricians, they might refer through…” (CMC)

In preparation for discharge from hospital, the level of support and information provided to each woman appeared to vary based upon the individual care provider, model of care, and health service. While the focus of the practitioners was on the care that was provided to women within the health service, for the women who were interviewed, being discharged from care presented new and unfamiliar challenges.

They just checked the stitches, made sure they were clean, made sure they were dry, but they didn’t explain any ongoing process...they just said if you have any problems go to your doctor.....Nobody explained anything. (Matilda)

At discharge, while some participants described receiving referrals for an endosalon ultrasound and receiving community midwifery support, other women reported that they received no support.

The endosalon ultrasound is meant to take place 5-6 months after birth. I just received a letter today stating that the appointment has been cancelled and rescheduled for 20 months after the birth. I haven’t experienced any problems (that I’m aware of, anyway)...however it’s very worrying that there is a 20 month wait for this follow up scan. (Indie)
For many women the level of support following SPT was inadequate in addressing their needs. Women described feeling confused and unsure as to when and where to seek support, particularly for women experiencing symptoms such as urinary incontinence, perineal pain and urinary retention. As they struggled to understand what degree of perineal pain and symptoms were normal and not normal following birth, they spoke of the importance of the role of health professionals in providing appropriate care, information, and reassurance to provide support in the postnatal period.

I didn’t know that it wasn’t right. I guess, you rely on the health care professionals to tell you. This is actually a pretty big thing that you’ve had, and this is the follow up you need, and this is what we need to do, and if you’re in pain let me know and I’ll get you something. (Chloe)

Support for women experiencing a subsequent pregnancy and birth appeared to vary across the NSW. CMCs reported that while some facilities offered no clear follow up services and subsequent birth planning and support for women who had sustained SPT during a previous birth, other facilities offered comprehensive support services. This appeared to be driven by motivated midwives:

It’s recognised at booking in that these women have got issues [as a result of SPT] – they’re just [scared of] the next birth and they’ve taken, maybe, five, six years even to get pregnant. So we meet and go over the last birth, it’s usually a debrief about the birth. Then there’s no set guidelines to what the birth will be. It depends on what experience was the last birth. That’s the way I make the plan, together in consultation with our clinical director. (CMC)

When asked to describe the general recommendations given to women in planning subsequent births, responses varied depending upon the opinion and preference of the individual medical officer, and the degree of ongoing morbidities experienced by the woman. For the women in this study, the decision making process for planning subsequent modes of birth was complex, with the participants describing how their decision was influenced by the advice they received and how much trust they placed in the health care provider:

The doctor that I saw when I was pregnant said you don’t need a caesarean. I said it’s really quite a sensitive subject and I really don’t want to have to explain but I think you should understand by me saying leaking and fistula. He said just don’t have a big baby this time. He said don’t eat – I swear to God – he said don’t eat so much. You won’t put on so much weight, you’ll have a smaller baby, you won’t tear. I just thought, that is the stupidest thing I have ever heard. (Loki)

Caring for women who have sustained SPT

How women were cared during the perineal repair process and in the postnatal period was a topic of concern for both the CMCs and the women. There were three identified areas of concern: the models of care within which women were cared for, whether the provision of postnatal care was focussed on the wellbeing of the newborn to the detriment of the new mother, and the provision of services for women who reside in rural and remote locations.

Continuity of carer During the discussion, continuity of carer was considered important for women who have sustained SPT during birth. It was believed that this would provide a level of consistency and be of value to women throughout any follow up consultations or diagnostic process:

The woman possibly has symptoms – she should have an open door if she’s got problems, to come back, so that she can be assessed by a midwife. Then, if there are significant issues, then it can be – some consistent care. (CMC)

Similarly, women described the value of receiving personalised, compassionate care from a known care provider, and the importance of receiving honest and accurate information communicated in a consistent and sensitive manner.

I really like that idea with the one midwife/one person – you know, you get a chance to iron out all the little crinkly bits before... it’s this whole womanhood, sisterhood, thing that I wanted to be a part of. (Ava)

The level of trust that existed between a woman and her health care provider appeared to impact upon whether or not the women felt in control, and therefore able to advocate for what they felt was important for themselves and their newborn. For women, the location that perineal repair was performed was an important consideration, and if given the choice of location the majority of women declined going to theatre due to their concern about leaving their newborn.

...they did say, oh we’re going to have to take you away for stitching. I’m like what are you talking about taking me away? I was like, if I’m going there, where’s my baby going to be? Oh well we’ll take her to the
nursery and I'm like, hang on, how long will I be gone for? I was like, whoa just back up a minute and I said Well why would you think that I would want to do that? I've just had my baby. (Grace)

The decisions that women made when considering location of repair were further influenced by the level of trust they had in their care providers and in the health care system. For women who were given a choice as to where the repair would occur, those who trusted their care providers and trusted that their newborn would be cared for appropriately followed the advice they were given. This was particularly noted for women who had continuity of care throughout their pregnancy, labour and birth.

So they asked whether I wanted to do it just under an epidural or whether I wanted to go under general anaesthetic. I said I didn’t really care either way. But then a doctor came in and said “No, you need it under general anaesthetic, it wouldn’t be pleasant or easy to do it under an epidural, it would be a bit too traumatic”. I was fine with that. So [the new baby] went off with Daddy, and I got wheeled off into surgery. (Sophie)

In contrast, the location where the perineal repair took place appeared to be influenced by both LHD policy and practitioner preference. It was reported in both the discussion and survey that the majority of fourth degree tears were repaired in theatre while the repair of third degree tears occurred either in theatres or in the room that the woman had birthed in. This decision was reported to be based upon both availability of theatres, staff, and individual preference of the health professional performing the suturing.

Fourth degree tears always go to the operating theatres. As far as third degree tears, for a number of years they need to go to operating theatres. The medical officers will not agree, they think they’ve done it for years and they can go ahead and keep on doing it, exactly where it is, because they think it’s perfectly alright. (CMC)

**Woman centred or baby centred care?** Women felt that following the birth, the focus of the health professional moved from the woman to the wellbeing of the newborn baby, and as a result the information women received focussed upon the care of the newborn with little concern as to the wellbeing of the new mother. Receiving honest and accurate information was seen as being of particular importance during the suturing process and immediate postpartum period. Women also described the need for health professionals to be mindful of the language that they used, and their facial expressions, when caring for women undergoing assessment and suturing of SPT.

They don’t have to say anything, but if you look at someone you can tell what they’re feeling. I mean you don’t work in a factory, you’re not sitting there sewing a little jacket, you’re helping somebody birth a child. (Matilda)

It was seen as important to the women that more of a focus was given to the health of the mother, including providing information on how to care for the perineum following discharge, any potential symptoms and morbidity that can occur as a result of SPT, and what women should do if any of these were to occur. Women reported that receiving this information as a leaflet, booklet or online resource would be beneficial as it could be reviewed when they were ready, and would also be easily accessible by their partner.

It would be good to have something if you did have questions to look through. You know they teach you how to wash the baby, and there’s all sorts of diagrams —but there’s nothing about aftercare for the mother except keep it clean, and make sure you can go to the toilet. (Ava)

Following discharge from the hospital, women described a need for a postnatal appointment conducted earlier then 6 weeks for a review of the perineal trauma, at this time women felt they would also have an opportunity to debrief, ask any questions and be provided with clear treatment pathway options if ongoing support was required. The women felt that ongoing support through a support group facilitated by a health professional would be beneficial as women worked to understand the physiological and psychological impact of SPT.

**Adding complexity to the picture: services in rural NSW** Support for rural women was described as beingunderfunded and poorly structured which resulted in inconsistent follow up with little consideration of the distances women need to travel to access care. For families living in rural and remote locations, it was acknowledged that women who required follow up care were faced with additional expenses associated with accessing follow up care, such as travel and accommodation costs, and this was reported as another reason why women were less likely to seek follow up care.

Anecdotally I would say that a lot of women don’t take that up (referral to a continence clinic)
because they don’t live locally. When you’re looking within our area the women are travelling up to 400 and 500 kilometres to get that follow up. It’s only if they develop ongoing problems that they develop a need, eventually, to some follow up. (CMC)

For immediate repairs of SPT, a lack of rural based services and minimal staffing means that for some women they require transfer to the closest tertiary facility which can occur by ambulance or using their family car. For repairs on site, repairs occur as a result of collaborative efforts by GP specialists (obstetricians, anaesthetists, surgeons) who combine specialties and conduct the perineal repair. Follow up care was reported as “variable” depending upon the location and availability of skilled professionals.

Over a very large geographic area it’s very hard to standardise practice or to track what kind of counselling or debriefing the women might get. It will entirely depend on which care provider they see. The advice they get in terms of the next pregnancy is going to be dependent on those individual care givers. (CMC)

During the interviews with women, there were no participants who resided in a rural location, therefore this perspective is limited to that of the CMCS.

**Gold standard care: how would it look?**

The CMCS who participated in the discussion group clearly identified the structure and delivery of a service that would provide a comprehensive model of care to women who sustained SPT during childbirth. This was determined as important, as asked during the discussion group if the CMCS felt that the incidence of SPT was increasing, the majority response indicated that they felt the incidence was increasing across NSW. In response to the survey question: “Rank in order from 1 to 10 (1 being most significant, 10 being least significant) what you feel contributes to the incidence of severe perineal trauma”, the most significant cause was identified as the position for second stage. The second most significant cause identified was instrumental birth (Table 3). The majority of the group identified that the key element in achieving a comprehensive level of state-wide care is consistency and standardisation of assessment, repair, treatment and ongoing care for women who sustained SPT. The implementation of mandatory reporting of cases of SPT including documentation of the degree of trauma, the method of suturing and the location at which the repair takes place, would facilitate clinical review, staff development, and the ability for audits to be conducted within the health services. It was suggested that this could be achieved through perineal repair training programs and an associated credentialing system for all health professionals who care for women who have sustained SPT, and the establishment of state-wide and national policies to guide standardised management across all health services.

I think consistency and standardisation of everything. That starts from all the psychosocial stuff, so that needs to be considered. Then there needs to be consistency with everybody; the skills of identification, the credentialing of the people most appropriate to repair, even the materials. I mean the evidence is clear out there that says all that. (CMC)

In response to the survey question “If there was anything that you could incorporate into your service for women who experience SPT what would it be?” the CMCS prioritised the importance for health professionals to be competent in accurately assessing and repairing perineal trauma. Further, in the survey responses the CMC participants identified the importance of providing women who sustain SPT with a comprehensive physiological follow up including a consultation with allied health specialists, including a physiotherapist and colorectal surgeon, and associated testing to determine the existence of any anal sphincter defects. Ideally these services would be offered within a specialist pelvic floor clinic with a known care provider where women would be provided with consistent evidence-based information. It was determined that this service would provide ongoing support for women through clearly structured treatment pathways. The group also identified the benefits of establishing such a service for women contemplating, or experiencing, a subsequent pregnancy and birth following SPT:

I think for the next birth it should be that they come to a specific clinic and see a consistent practitioner in that clinic – either a midwife or an obstetrician – so that the birth plan can be formulated for them. (CMC)

It was identified that this support was also required for women who resided in rural and remote locations, ideally with the establishment of a multi-disciplinary team that would be made available for women who required assessment, support and ongoing care.

**Discussion**

This study reports on CMCS and women’s description of health service provision for women who have sustained SPT following vaginal birth in NSW. It was apparent that there was a patchwork of policy and processes that were identified by both CMCS and the women as problematic. While the CMCS were focussed on the
technicities of perineal repair and the processes of service provision, and women who have sustained SPT were more concerned with how they are cared for and treated by health care professionals, the CMCs clearly identified and were concerned about the impact of the “patchwork” system on the care provided to women.

Risk factors for severe perineal trauma
Risk factors during the antenatal period associated with an increased incidence of SPT include parity, maternal age, ethnicity, nutritional status, fetal weight and abnormal collagen synthesis [5,28]. Intrapartum risk factors include medio-lateral and midline episiotomy, instrumental birth using ventouse and/or forceps delivery, a prolonged second stage of labour, and the birth position adopted by the woman during second stage [29–33]. The CMCs who participated in this study identified antenatal and intrapartum risk factors for SPT, identifying the position for second stage as the factor most likely to contribute towards a woman sustaining SPT. In addition, instrumental birth and episiotomy were identified as intrapartum risk factors, which correspond with what is currently known about risk factors for SPT [4,5].

Suturing the perineum – the importance of compassionate care
Research reporting upon the repair of SPT focuses on the outcomes of immediate and long term morbidities, however little research has examined women’s experience of perineal suturing [33,35]. While the CMCs were focussed upon who was the most appropriate health professional to undertake the repair of SPT, the women who were interviewed focussed upon how much information they received regarding the repair, whether the actions of the health care professional undertaking the repair were appropriate, and how the process of suturing interfered with their ability to spend time and bond with their newborn.

Similar findings were reported in a prospective study conducted by Green et al. (1998) [36] who explored women’s experiences and expectations of childbirth, and their subsequent levels of satisfaction or dissatisfaction with the outcome [36]. Women who sustained perineal trauma describe perineal suturing as the “worst thing about birth” [36], p. 348, when reflecting upon the level of pain they had felt during the procedure, the lack of information they received about the repair, and being separated from their newborn baby during the procedure.

Some argue that health professional training is currently focused on the development of technical skill and less on the importance of providing woman-centred compassionate care [37]. The importance of compassionate care has been identified by the NHS Commissioning Board (2012) in the policy document “Compassion in Practice” (NHS Commissioning Board, 2012). This document identifies ‘compassion’ as one of the six fundamental ‘Value and Behaviour’ practices which sits alongside care, competence, communication, courage and commitment (referred to as the “6Cs”). Compassionate care is described as “…how care is given through relationships based on empathy, respect and dignity - it can also be described as intelligent kindness, and is central to how people perceive their care. (NHS Commissioning Board, 2012, p. 13). The women in this study were able to clearly recall the way they were treated by health professionals throughout their labour, birth and postpartum period, and this treatment impacted upon the way women recovered from and processed their experience both negatively and positively.

Clinician training
Little research has evaluated the training process for health professionals in accurately diagnosing and performing repair of SPT. It is recommended that a thorough assessment of trauma to the perineal, vaginal and anal sphincter regions immediately following birth is performed by an appropriately qualified health professional who is trained in pelvic anatomy and correct suturing techniques of the perineum [2,38–40]. Comprehensive examination is recommended both prior to, and following, suturing to ensure correct repair has been performed [38]. The CMCs who participated in the discussion group described the variation and inconsistencies across current NSW health services as to the minimum level of training required for health professionals to appropriately repair SPT. Perineal assessment performed by inadequately trained staff can lead to misdiagnosis of the degree of perineal trauma and consequently result in inadequate and inappropriate treatment, morbidities such as wound breakdown and abscess formation, and the development of co-morbidities such as recto-vaginal fistulae [3,41–43].

Previous studies reporting upon the ability of health professionals to accurately identify and repair second degree perineal trauma have identified that the majority of midwives, trainee doctors and obstetricians describe their training and professional support as inadequate [37,44,45]. In a cross-sectional survey examining current practice, experience and confidence of obstetricians in the management and repair of SPT [46], the authors reported that the majority of obstetricians (95%) described themselves as confident in repairing SPT. Despite the level of confidence reported by the participants, the findings are similar to those of this study in demonstrating that there is a lack of consistency in the practice of SPT repair, with the participants identifying that a local guideline or protocol would be useful in guiding their practice [46].

Postnatal referrals and pathways of care
The World Health Organisation state that despite the postnatal period being one of the most critical in contributing
to optimal maternal and neonatal health, they describe the delivery of postnatal services as "... the most neglected period for the provision of quality care." [47], p. 3. Bick (2005) states: "Despite pain being experienced by hundreds of thousands of women who give birth each year in the UK, and many more worldwide, identification and management of perineal morbidity...has not been a high priority. The postnatal management of more severe perineal trauma...has also been relatively neglected" [48], p. 113. This neglect is reflected in through the lack of current research that has been conducted into postnatal services.

The CMCs who participated in this study identified that postnatal services varied depending on the LHD and the practice of the individual health practitioners. This inconsistency in service provision was also reported by the women; while some women received postnatal support and referral to service and diagnostic examinations, other women received no follow-on care or support postnatally. Similar findings have been reported elsewhere, with women describing feeling let down by the health system as they try to manage ongoing morbidities with little to no support [9,10].

In this study women identified that the level of information and support they received following birth impacted upon their ability to identify what is normal and what is not normal during the postnatal period, and seek help accordingly. Consent advice guidelines distributed by the Royal College of Obstetricians and Gynaecologists (RCOG) highlight the importance of providing the woman with detailed information irrespective of the extent of the perineal trauma that has been sustained [49]. However, despite the availability of these guidelines, the women in this study reported that they were often provided with little or no information in relation to the degree of perineal trauma they had experienced or the process of perineal repair therefore making it difficult for women to know what is normal and when to seek help.

Gold standard care
It has been suggested that multi-disciplinary collaborative specialist clinics are required for women who sustain SPT, with the aim of providing comprehensive physiological and psychological support within the one facility [50-53]. Both the CMCs and the women who participated in this study identified the importance of support for women who sustained SPT, ideally provided by a known care provider. Additional benefits of establishing specialist perineal clinics are reported to include an efficient model of specialised health care, facilitating ease of access for women requiring services. This approach is supported by Chutoor et. al (2009) [51] who states: "The multidisciplinary team approach is a means of synchronising treatment between various specialties and streamlining the patient pathway [51], p. 614.

Limitations
This study focusses on midwives experiences of caring for women who sustain SPT, however the CMC participants of this study come from metropolitan and rural NSW, Australia, therefore the context of these findings were specific to NSW and these findings may not be transferable to services in other States and Territories in Australia, or internationally [54]. While the context of these findings may be transferable, it would be important that the findings were related to the new context. For this study, a descriptive qualitative research design was chosen to facilitate a greater understanding of the topic under investigation, however due to the time limitation of the discussion group (one hour) and large number of CMC participants, this presented challenges in exploring in detail the CMC perspective of service provision [17,54]. Limitations that arose during the recruitment and interviews with women have been described in a previous publication [12]. No women who resided in a rural location were included. Strengths of this study include the use of an integrative approach which provided a comparative analysis of similarities and differences in the way women and CMCs view service provision for women who sustain SPT, this approach provides a deep understanding of complex phenomena as for this study [24,25].

Conclusion
The findings from this study suggest that current health services in NSW represent a patchwork of service provision for women who have sustained SPT. This is characterised by a discrepancy between the services that are provided, and the needs of women. It appeared that women who experience SPT and associated postnatal morbidities seek compassionate and supportive care based upon a clear exchange of information, and this should be considered when reflecting upon the current health service design. This study highlights the benefits of establishing a comprehensive, multi-disciplinary collaborative specialist clinic to support women who experience SPT and associated morbidities, with the aim of providing comprehensive physiological and psychological support.

Abbreviations
LHD: Local Health Districts, encompass all health facilities which operate within a geographical area determined by NSW Health. CMCs: Obstetrics and Gynaecologic Registrar. A doctor who is undertaking specialist training in obstetrics and gynaecology. RMO: Resident Medical Officer. A doctor who has completed a medical degree and a 12 month internship, and are eligible for full registration with the medical board. WMO: Visiting Medical Officer. A doctor who provides medical services for hospital patients on seasonal or for service basis.

Competing interests
The authors declare that they have no competing interests.
Authors’ contributions
HP participated in research design, data collection and analysis, design and drafting of manuscript in a component of a doctoral study. MC assisted with research design, data collection, review of data and manuscript drafts. VS assisted with research design, review of data and manuscript drafts. CC and AS assisted with identifying literature for the discussion, review of data and manuscript drafts. All authors read and approved the final manuscript.

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6.2 Chapter conclusion

This chapter presented the findings from a discussion group and survey conducted with the CMCs of NSW in the paper titled: ‘“A patchwork of services” – caring for women who sustain severe perineal trauma in New South Wales – from the perspective of women and midwives’. This paper described the current health service provision for women who have sustained SPT from the perspective of midwifery leaders and women. The following chapter presents a paper currently under review presenting my personal experiences as an autoethnographer undertaking this doctoral study.
Chapter Seven: Autoethnography and severe perineal trauma – an unexpected journey from disembodiment to embodiment.

7.1 Relevance to thesis

Chapter Seven presents the paper titled: ‘Autoethnography and severe perineal trauma – an unexpected journey from disembodiment to embodiment.’ This paper is currently under review, and has been formatted according to the guidelines for submission required by the journal to which the paper was submitted.

This paper describes autoethnography as a methodological approach, and my personal experiences of undertaking this research as both a doctoral candidate and a woman who has sustained SPT and experiences ongoing morbidities.
Title Page:

Autoethnography and severe perineal trauma – an unexpected journey from disembodiment to embodiment.

Priddis, H.

Abstract

Background: There is a lack of research reporting on the physical and emotional experiences of women who sustain severe perineal trauma (third and fourth degree tears). When the researcher identifies with the group being researched, autoethnography can allow an insight into the experiences of the marginalised group through the telling of a personal story. The aim of this paper is to share the journey travelled by an autoethnographer who on examining the issue of severe perineal trauma came to understand the challenges and rewards experienced through this reflective and analytic process.

Methods: A transformative emancipatory approach guided the design, data collection and analysis of findings from this mixed methods study. For this paper, a multivocal narrative approach was taken in presenting the findings, which incorporated the words of both the autoethnographer and twelve women who were interviewed as a component of the study who had sustained severe perineal trauma.

Results: As an autoethnographer, being a member of the group being researched can be confronting as the necessary reflection upon one’s personal journey may lead to feelings of vulnerability, sadness, and emotional pain. The transformation from disembodied to embodied self, resulted in a physical and emotional breakdown for this autoethnographer.
Conclusion: Autoethnographers may experience unexpected emotional and physical challenges as they reflect upon their experiences and research the experiences of others. When incorporating a transformative emancipatory framework, the challenges and hardships are somewhat balanced by the rewards of witnessing transformation as a result of the research.

Keywords: Autoethnography, severe perineal trauma, mixed methods, qualitative, postnatal morbidities.

Background

Perineal trauma occurs during vaginal birth when injury is sustained to the perineum (the area between the vagina and the anal sphincter). Severe perineal trauma (SPT) is when injury occurs to the perineum with trauma extending to the anal sphincter complex (third degree tear); or a fourth degree tear, which involves injury to the perineum involving the external, internal and epithelium of the anal sphincter (RCOG, 2007). The majority of research on the topic of SPT focuses on risk factors and causes, and the methods of repair to minimise short and long term morbidities (Buppasiri et al., 2010; Fernando et al., 2010; RCOG, 2007). Morbidities that can occur following SPT are as a result of damage to the surrounding nerves, disruption of the anal sphincter complex, and extensive scarring of the perineum and anal sphincter. Following SPT, some women remain asymptomatic, whilst other women may experience symptoms including urinary, flatus and faecal incontinence, haemorrhoids, and dyspareunia (Bagade & MacKenzie, 2010; Rathfisch et al., 2010; Tin et al., 2010).

In addition to the physical morbidities that women experience as a result of SPT, there is evidence that women may face multiple psychosocial challenges as a consequence of this birth related trauma (Priddis, Dahlen, & Schmied, 2013; Way, 2012; Abimbola Williams, Lavender,
Richmond, & Tincello, 2005). Studies report experiences of social isolation and marginalisation due to ongoing symptomatology, particularly those symptoms including perineal pain, urinary and faecal incontinence (O'Reilly, Peters, Beale, & Jackson, 2009). Previous research has suggested that SPT may also alter a woman’s understanding of her identity as a sexual being, as morbidities may affect her ability to engage in sexual activities and as a result impact upon her relationship with her significant other, and her sense of self (O'Reilly et al., 2009; Priddis, Dahlen, & Schmied, 2013; Abimbola Williams et al., 2005). However, despite the impact that SPT has on the physical and emotional wellbeing of women, little research has been undertaken exploring the experiences for women who have sustained SPT. This is concerning given SPT is an increasing reason for litigation in maternity care (C. Henderson & Bick, 2005; C Kettle, 2005).

I undertook a mixed methods study with the aim to understand the experiences of women who have sustained SPT using a transformative emancipatory framework. The motivation for the research that I undertook for my doctoral research project was transformation. My goal was to bring about change in health service provision and care for women who have sustained severe perineal trauma (3rd or 4th degree tears) during childbirth. Papers have been published on the findings of this research: reporting the prevalence of SPT from 2000 – 2008, the risk of recurrence, related morbidities and subsequent modes of birth for women who experience SPT; the experiences of women who sustain SPT (Priddis, Dahlen, & Schmied, 2013; Priddis, Schmied, & Dahlen, 2014); and current service provision in New South Wales, Australia from the perspective of Clinical Midwifery Consultants and women (Priddis, under review).

An autoethnographic approach
I took an autoethnographic approach to this study as I had my own experience of a 4th degree tear following the birth of my second baby, and the resulting long term consequences have had a significant impact on my physical and emotional wellbeing. I hoped that by acknowledging the journey of women, and through disseminating my work, I would inspire reflection in health professionals to create change within themselves and the health services within which they work. It has been proposed that a transformative-emancipatory framework is a way of developing a critical investigative research design and advocating for change through the research process for marginalised groups (J. W. Creswell, 2007; Mertens, 2009). When a transformative-emancipatory paradigm is used, the researcher may be a member of the marginalised group as a result of illness, circumstance or from birth. Through my personal experience of SPT I was able to self-identify with the marginalised group under investigation, therefore, I chose to take an autoethnographic approach.

Autoethnography arises from a combination of an autobiographical approach and ethnographic methodology, which focusses specifically on reflexivity and self-consciousness (Anderson, 2006; Ellis & Bochner, 2006). When incorporated into a research project, the experiences of the autoethnographer are considered vital to the data in understanding the marginalised group of which they are a part (Anderson, 2006). Ellis (2013) describes autoethnography as not only a way of knowing about the world, but “has become a way of being in the world, one that requires living consciously, emotionally, and reflexively”, and that as autoethnographers we must “…observe ourselves observing, that we interrogate what we think and believe…” (Ellis, 2013, p. 10).

During the conduct of this research and through the process of using an autoethnographic perspective, what I did not anticipate was the transformation that would occur within myself. I
had expected that the research would present personal challenges as I reflected upon my own experience, but I was overwhelmed and unprepared for how confronting this reflection process would be; how emotionally – and consequently – physically challenging this journey would be. Therefore this paper explores the journey of the autoethnographer within this study and the insights gained into this important area of women’s health. It further explores the harrowing personal toll, and soul searching, that eventuated along the way for this researcher as a consequence of using an autoethnographic approach. This paper is presented as a multivocal narrative (Tomaselli et al., 2013), as woven throughout my words and personal reflections are the stories of the women who participated in this research project as a way to identify contrasts and similarities between my story and the stories of other women who have sustained SPT. The quotes that are used are directly from the interviews with the women, those that have been published the publication has been cited. Pseudonyms are used to protect the identity of the women.

Methods

The growth of autoethnography as a methodological approach conflicts with traditionalist perspectives which value objectivity, validity and reliability in the design and analysis of research, as a result there are multiple definitions and presentations of this methodological approach (Ellis & Bochner, 2006; Muncey, 2010). Evolving from the work of ethnography, whereby the researcher explores meaning behind behaviour and interactions in a specific cultural group within a natural context, autoethnographers identify their position within the cultural group being researched and weave their personal experience in to the analysis and interpretation of the collected data (J. W. Creswell, 2007; Hammersley & Atkinson, 2007;
Jones et al., 2013). There are two key autoethnographic approaches in research design, analysis and presentation – evocative or emotive, and analytic.

Two autoethnographic approaches

The origins of autoethnography draw upon emotion, an autobiographical presentation of the journey of the researcher, and are therefore described as evocative (Muncey, 2010, Ellis, 1999). Evocative, also described as emotive, autoethnography values the story of the autoethnographer, however it “transcends mere narration of self to engage in cultural analysis and interpretation” (Chang, 2008). Through a reflective writing process, autoethnographers make themselves vulnerable as they share their own story to benefit the group they are researching. As stated by Denzin (1997), autoethnographers “…bypass the representational problem by invoking the epistemology of emotion, moving the reader to feel the feelings of the other.” (N. Denzin, 1997, p. 228).

When undertaking analytic autoethnography, Anderson (2006) suggests that there are five key features: complete member research status, analytic reflexivity, narrative visibility of the researcher’s self, dialogue with informants beyond the self, and commitment to theoretical analysis (Anderson, 2006). Analytic reflexivity requires the researcher to have an awareness of their place within the research and the potential impact this has upon the interaction with study participants and interpretation of data (Danaher et al., 2000). The use of analytic reflexivity ensures objectivity and authenticity throughout the research process (Anderson, 2006; Vryan, 2006). However this does not sit well with those who value evocative autoethnography, with Ellis and Bochner stating (2006): “If you turn a story told into a story analysed...you sacrifice the story at the altar of traditional sociological rigor. You transform the story into another
language, the language of generalization and analysis, and thus you lose the very qualities that make a story a story” (Ellis & Bochner, 2006, p. 440).

In response to the division between the emotive and analytic approaches of autoethnography, Tedlock (2013) presents examples of autoethnographic literature where authors have chosen to interweave both emotive and analytic approaches in writing (Tedlock, 2013). In the work presented by Giorgio, she demonstrates this interweaving of both approaches through her reflection: “When I sit down to write, I find the story behind the memories; I then begin to make sense of those memories, their meaning for me and for others” (Giorgio, 2013, p. 406). As a novice autoethnographer I valued both the emotive and analytic perspectives, and felt it necessary to combine both approaches not only to truly embrace and travel the bumpy road that is the autoethnographic journey, but to fulfil doctoral research requirements.

Positioning myself amongst the participants

In this study, while I am considered a member of this marginalised population, I acknowledged that the experiences of the women who have sustained SPT are individual, therefore my position as complete member researcher provides one perspective on exploring the experience of the marginalised group (Danaher et al., 2000). In depth interviews were conducted with 12 women who had sustained SPT, with the purpose of the interviews to explore the way women understand and have experienced SPT, including their experiences of, and interactions with, health services. The recruitment, participation process, demographics of participants, and findings have been previously published (Priddis, Schmied, & Dahlen, 2014). During the interview process, I provided full disclosure as to my experience of a fourth degree perineal tear and associated morbidities. This disclosure immediately allowed for identification as an “insider” and facilitated a more open discussion. The role of insider occurs when the researcher
has dual identities as both researcher, and as a member of the marginalised group being researched (Burns, Fenwick, Schmied, & Sheehan, 2012; Condell, 2008). During a few of the interviews an interesting shift occurred following disclosure of my experience, whereby the women – as a result of identification with my experience – became the interviewer. The women were curious as to my daily management strategies, recovery following treatments and surgeries, with a particular focus on sexuality and the practical aspects of intercourse with my partner. I let this transference of ownership of the interview evolve and follow the path set by the woman, to see where the journey would end.

The autoethnographer, as a result of critical self-reflection, may experience a change in perspective as a result of the research itself (Mertens, 2009; Spry, 2001). This is further explored by Schwalbe (1986) who describes the impact of autoethnography on the researcher: “Every insight was both a doorway and a mirror – a way to see into their experience and a way to look back at mine.” (Schwalbe, 1996, p.58). In reflecting on the roots of autoethnography, Bochner described how autoethnography found strength as an alternative to the limitations found in the social sciences, and “feeds a hunger for details, meaning and peace of mind” (Bochner, 2013). While the growth of this qualitative genre has allowed for personalised interpretations and explorations of experience, “peace of mind” is not always something that is experienced by the autoethnographer, and this certainly rings true for my own experience which will be explored in this paper (Defrancisco, Kuderer, & Chatham-Carpenter, 2007; Pearce, 2010).
My story

My first baby

My first baby arrived when I when I was nineteen. Now, twenty years later, I am unable to recall every part of my son’s labour and birth. I remember feeling overwhelmed and alone, even though my family were in the room, and requesting pain relief. I remember pushing on my left side, one midwife holding my leg in the air and the other midwife saying “You are tearing, we need to cut you”. I didn’t feel the episiotomy; following this my son was born, not breathing. I remember bells and alarms and resuscitation, and after a scary amount of time he was brought to me, my seven pound one ounce wrinkly little boy. And then I remember the suturing by a doctor I did not know. It was so incredibly painful, and frightening. And even with the sleepless nights, the cracked nipples and mastitis, what I most vividly recall is the suturing.

The women in this study described that feelings such as vulnerability, discomfort and fear were directly related to the way in which they were cared for by their midwife, obstetrician, and the health professional undertaking the repair. Women described these interactions as often inappropriate, recalling the facial expressions and the way health professionals often did not communicate directly to the women but discussed her perineum between themselves:

“And [the doctor] didn’t really want to talk while she was suturing, she just had this disgusted look on her face when she was doing it. It was horrible, it wasn’t nice…” (Ava) (Priddis, Schmied, & Dahlen, 2014, p. 4).
My second baby

When I became pregnant with baby number two, five years later, those memories were still fresh and raw. It was important to me that those experiences weren’t repeated, that my baby was born safely, that my body was supported to give birth without trauma. I found a midwife in a birth centre that I connected with, who provided the care that I needed. I carry her name forever in my heart, and she ultimately became one of the core reasons I became a midwife.

Following a long labour when I reached second stage, I had an overwhelming urge to push and an instant relief. My 9 pound 5 ounce daughter was born following a nine minute second stage.

I didn’t feel the tear. After some skin to skin, attempts at breastfeeding and bleeding that would not settle, my midwife examined me and looked concerned. She bought a doctor in who did a second examination and then explained to me that I had a 4th degree tear, down to and through my anal sphincter. I was shocked. I was then taken to a treatment room, I left my new daughter with my husband, and multiple injections of lignocaine and excruciating pain later, had the fourth degree tear of my perineum sutured. What got me through this experience was the most beautiful student midwife who came in with me, held my hand, and murmured comforting words to me while I cried in pain.

Research has reported that women experience fear around the anticipation of pain during the suturing process, the damage sustained to their perineum, and that they may be sutured incorrectly resulting in further perineal damage (Priddis, Dahlen, & Schmied, 2013; Salmon, 1999). For some women, they described how they also experienced pain during the process of perineal assessment and suturing:
“...there was a doctor that came and had a look. She was quite rough, I thought. She was really poking and shoving gauze in there. I was screaming my head off. It was really awful.” (Indie)

I went back to the hospital two weeks after my daughter was born. I remember discussing my breastfeeding issues, but nothing else. I had my 6 week check up with my GP, who read my notes, put his finger into my anus – remarked that it felt fine, and I was sent home.

*In this study, women described the value of receiving comprehensive information and compassionate care following the birth, however these appear to be lacking in the current system* (Priddis, Dahlen, & Schmied, 2013; Priddis, Schmied, & Dahlen, 2014).

“I think [the doctor] could have definitely told me who to call if I had any problems. I wasn’t given any numbers or information or anything. Maybe just some recovery tips, or I think they could have told me what happened. I think the system let me down, I think it did. I’d like to think that other women who go through this have a lot more support...” (Lola).

*My leaking body*

Three months after my daughters’ birth I had a dentist appointment. I remember parking the car, going up the escalator into the shopping centre where the dental rooms were. I was walking along when I felt something run down my legs. I quickly ran to the toilet, thinking perhaps I had gotten my first period. But I was horrified to see that I had become incontinent for faeces. I remember sitting in the toilet, crying, wondering what on earth to do. I threw my underpants out, and I tried to clean myself, luckily I had nappy wipes in my handbag and I used those to clean myself the best I could. Once I composed myself I went into a chemist and used one of
their sample perfumes to spray myself, I was completely paranoid that I smelt of faeces. I still had to go to the dentist appointment but the whole time I lay there praying that I didn’t smell and that no more would run out. I have never forgotten that day, or the absolute disgust that I felt with myself that I had no bowel control.

‘A leaking body’ is described in the literature as immature (Braidotti, 1997; Davis-Floyd, 2001); this link was reflected in the words of women who described uncontrollable bodily functions, particularly faecal incontinence, as being dirty like a toddler, or a naughty child (Peake, Manderson, & Potts, 1999; Priddis, Schmied, & Dahlen, 2014). Studies also report the efforts women make to conceal body functions, including menstruation, urinary and faecal incontinence, to conform to cultural and societal norms (Farrell et al., 2012).

“…part of me thought ‘[my best friend] will judge me if I tell her that I’m poohing my pants’. Not that I think she would’ve thought any less of me, I’m sure there would have been sympathy, but I thought it was disgusting so I didn’t want anybody else to judge me for that…” (Matilda)

Over time I developed strategies for dealing with the episodes of faecal incontinence. I always had spare underpants and nappy wipes in the baby bag that I carried with me. I drank minimal amounts of water, I found being constipated an easy way to manage bowel control. I saw my GP but he just suggested doing more pelvic floor exercises, but with minimal control over my pelvic floor I struggled to do more than two at any given time.

In my study women described how they were required to manage their daily living activities, such as sporting activities and recreational outings, as they risked
experiencing an unexpected episode of urinary or faecal incontinence. Management strategies include avoidance, or limiting activities and outings to places where there were easily accessibly toilet facilities (Herron-Marx, Williams, & Hicks, 2007; O'Reilly et al., 2009; Priddis, Dahlen, & Schmied, 2013). Further management strategies that women have reported include the style of underwear and clothing that they were required to wear to camouflage the use of incontinence pads, and to avoid further irritation of the perineum and associated pain (O'Reilly et al., 2009; Priddis, Dahlen, & Schmied, 2013).

“Time went on and I just kind of changed a few things, like stopped wearing G-strings and carried wipes and spare undies around. I just adapted my lifestyle to it.” (Lola) (Priddis, Schmied, & Dahlen, 2014)

More babies and more symptoms

Over the next two and a half years I had two more children by caesarean section. Each pregnancy made my symptoms worse. Throughout my fourth pregnancy my perineum felt heavy, weak and the inability to complete bowel movements occurred with every trip to the toilet due to a lack of control that remained of the anal sphincter muscles. Now a mother of four, I was becoming nervous about leaving the house following the memory of the trip to the dentist all those year ago, and the fear of being incontinent. But I put up with it. I looked after my babies, commenced my midwifery training, and did all the things mothers do. After attempts at repairing the damage through surgery, then developing a temporary fistula as co-morbidity, to this day fourteen years after my fourth degree tear, I have ongoing incontinence of flatus, and difficulty holding onto faeces for any length of time. I experience pain in my perineum and anal sphincter.
The need to do this study

It is perhaps not surprising then that I wanted to explore this issue for women in the state of NSW where I live for my PhD. Reading about autoethnography as a methodological approach made me realise that while potentially painful, this would provide an additional depth to the analysis of the data. As Allen and Piercy (2005) describe: “In that place of vulnerability, I am more open to hearing the voices of others, particularly those in marginalized positions. I am less ready to dismiss the experiences of others, or to superimpose theories that will distance myself from connecting with them.” (Allen & Piercy, 2005, p. 160). Autoethnography provides a platform from which I can detail and express my process of embodiment and the consequent outcomes.

As researcher as woman as researcher

The use of autoethnography can be seen as both a strength and limitation in conducting qualitative research. Whilst being a member of the marginalised group provides an “insider” opportunity for the researcher when recruiting and interviewing participants, a limitation is that the research process can be confronting for the autoethnographer as the process of conducting research and the necessary reflection upon one’s personal journey is similarly confronting, leading to feelings of vulnerability and emotional pain (Ellis, 1999; Muncey, 2010; Pearce, 2010). To address the potential for recollection bias in presenting research from an analytic autoethnographic perspective, it is important that the researcher is visible, reflexive to ensure objectivity and authenticity, and committed to theoretical analysis (Anderson, 2006).

As I remained constantly mindful that my experiences were not those of the women, and that each story stood alone, I was often struck by the similarities of our stories and as I reflected...
upon the coping mechanisms adopted by the women, I - in turn, reflected upon my own. In the process of conducting this study, this level of critical self-reflection was both confronting and upsetting, as this level of reflection revealed that I had moved towards a “completely different normal” by compartmentalising the perineal morbidity and associated long term symptoms. This theme was identified by the participants in one of the studies I undertook (Priddis, Schmied, & Dahlen, 2014). However in order to be reflective and analytic during the process of thematic analysis, this coping process of compartmentalising needed to be pulled aside so that I could become fully immersed within the data. Viewing the damaged perineum from a mechanistic viewpoint, as a faulty object, a disembodied or component part, had been protective and safe, while the paternalistic discourse of the feminine body as weak and inferior was confronting and upsetting. Autoethnographers have explored this dualistic role of autoethnographer and self, with Olson (2004) stating: “The dualistic role of a personal survivor and an academic is a reflexive one, each informing the other, never separate from one another” (Olson, 2004, p. 7).

The relationship that I developed with the women who participated in the study, following full disclosure of my own experience, fostered a closeness that remains to this day. Many of the women have remained in contact with me to report follow up assessments and test results, subsequent babies and general wellbeing. This has been a double edged sword as although I am humbled that these women have taken me into their hearts as a confident, it has been accompanied by an emotional burden that has weighed heavily on my heart.

**Reflections: autoethnographic discoveries**

During my doctoral candidature my understanding of the topic I have researched, what it is to be an insider, an autoethnographer, and the enormous impact this has had on me personally I
feel is best represented by sharing with my personal field notes or “reflections”. These reflections included both the use of a personal online journal, and a summary of emails that were sent to my primary research supervisor as I attempted to make sense of my experience.

This is one of the first reflections that I completed:

(21st November, 2011)

*Five interviews so far. I expected to find this journey challenging, however I am finding it difficult in different ways than what I expected. I thought that hearing the stories told by women would make me reflect upon my own ongoing experiences and that that would be confronting. However, what I am finding distressing is that women have experienced pain, incontinence and feelings of distress around their birthing experience....*

Within this same reflection my beginner level understanding too of what autoethnography was is apparent here:

*Threading autoethnography throughout the interviews does not always feel appropriate to me. When a woman is distressed, or has experienced extensive physical and psychological ramifications – I feel it is inappropriate to tell my story, that it takes away from the woman’s own experience.*

Three days later I had completed 8 interviews and my perspective was slowly shifting:

(24th November, 2011)

*During this time I became more aware of my own body, my inadequacies (as I perceived them) were magnified, and I was more aware than ever of my pain and the inability of my body to function as it should. Although I felt relief for the women who participated in my study who did not experience any symptoms following SPT, at times I felt a*
sadness, and to this day wonder why my body just would not heal as theirs had. I share their sorrow, their fear and understand why they try to dismiss these feelings as being ‘all in the mind’.

There is then a gap of nearly a full 12 months between my recorded reflections, and the next reflection describes why:

(6th December, 2012)

I had expected that the challenge would be in interviewing women that I would be confronted by their distress and that would be the most challenging part of my doctoral journey. Whilst I empathised and sympathised with these women, I left each interview a little saddened but mostly inspired to represent these women honestly and with respect, to advocate and instigate change.

One afternoon that changed. My own personal symptoms had been exacerbated as a result of stress of my parenting/academic workload, and one afternoon as I was doing preliminary coding of transcripts, I became overwhelmingly upset and cried. And cried and cried. This crying continued for weeks, into months, and I assumed that this occurred as a result of my workload and transcript coding. I took a temporary breather to refocus and explore why I had responded this way.

Crisis Point – the process of a break down

I was given the amazing opportunity of being invited to present my research in Canada, a trip and opportunity I was extremely excited about. However, when I arrived in the first airport following the long haul flight I became extremely physically unwell with severe gastric symptoms that lasted the duration of my time in Canada. While I was still able to present my
research I spent the majority of my time on, or near, a toilet. During this experience I was highly anxious and I remained unwell on the return home, and for the following months. I lost a substantial amount of weight due to chronic gastric problems, and a loss of appetite. I was restless, depressed and became increasingly withdrawn. I was unable to focus on work due to the restlessness and overall physical exhaustion due to the weight loss, and was unable to present my work at conferences that I had been invited to speak at.

Following many appointments with medical professionals, and surgery to identify the cause, it was found that I had not only been unwell as a result of a parasite when travelling, this stress had initiated a physical response, meaning I was now intolerant to gluten and lactose. It had further been the catalyst to trigger an overwhelming emotional response; I was experiencing depression and anxiety. I felt helpless and overwhelmed, in a state of panic each day. I was truly frightened by what was happening, I thought I was simply going crazy. On any given day my body was constantly “humming” – preparing me for fight or flight. This constant humming meant I need to be moving or standing at all times, trying to keep my body as busy as my brain, as it bounced from one thought to another unable to keep still or focussed. My house was spotless as I crawled around on the floor cleaning skirting boards at six in the morning!

So the anxiety then became a cycle – my body felt fearful or anxious, then my gastric system became upset, then I am concerned that if I am out somewhere, away from a toilet, I will have a gastric episode and so then that triggers the anxiety. I do admit, when I was in the darkest of places, that death looked attractive. However to clarify, I was not suicidal but merely considered the peace that would come with death as a reprieve from the chaos, whenever it happened.
Disembodiment, embodiment and coping

In reading the stories told by the women, and undertaking my meta ethnographic synthesis I became interested in exploring the concepts of embodiment versus disembodiment, whereby the dysfunctional component of the body is identified as being either part of the person or as a separate (disembodied) entity (Lupton & Schmied, 2013; Young, 1984). Through reading, and my own personal journey as I attempted to rediscover my sane self, I realised that for the past 14 years since the birth of my daughter, my coping strategy was based upon disembodiment – that separating my traumatised perineum from my personal self, allowed for me to continue with my life and multiple commitments, as a doctoral candidate, mother of four children including one with a disability and running a business, without my ongoing morbidities affecting me on a personal, intimate level. The women I had interviewed described this disembodiment that I had not realised that this is what I had done to survive.

On reflection, I recalled days when I experienced varying degrees of incontinence or pain I would describe them as my “bad bottom” days to those close to me, externalising the “bad bottom” and placing it as an object, clearly disembodying from the process.

Whilst this strategy of coping had served me well, a strategy I was comfortable with, being disembodied would not allow me to truly delve amongst the research and represent the stories of the women that I interviewed as I needed to. I had subconsciously adopted an embodied view of my severe perineal trauma and was not coping at all. I had uncovered a part of myself, a vulnerability and depression, which placed me in an uncomfortable place – confronting, dysfunctional. My ability to multi task my crazy life was lost, I jumped from one task to another trying to keep on track (unsuccessfully). I did not like the part of me that had emerged, I felt
vulnerability as a weakness, and this conflicted directly with my role as a strong, efficient, perfectionist working mother.

**Re-emerging as the embodied/disembodied woman**

I knew that I had work to do - completing my PhD within my timeline, representing the women’s stories with honour and respect was important to me. So I started working again, on other things – I avoided the interviews for a while. All the de-identified interviews sat in a blue zip up folder, I found it difficult to be near or look at this folder which I kept in my study. Then, after time, I was able to carry the folder with me to research supervisory meetings, but unable to open the folder, and to this day I feel physically unwell whenever I see that folder which has now been stored away. I transitioned my focus to the quantitative component of my research and reading autoethnographic literature. It was important to me to find others who had travelled a journey similar to mine to understand how they survived this process:

(23rd May, 2013)

….and then I turned to autoethnography literature. I surrounded myself with the works of others who had travelled the autoethnographic path. And in doing this, I discovered a sense of camaraderie, a support group of researchers around the globe who too had travelled this journey and confronted their own personal demons. Their words wrapped around me and provided warmth and comfort for my saddened soul.

The solace I found in the works of these amazing autoethnographers (N. Denzin, 2014; Ellis, 2013; Muncey, 2010) not only provided me with strength to complete my work, but ignited in me a true passion for what autoethnography is. I have always been a writer but to write in this way has been such an incredible privilege for me.
Caring for the autoethnographer

In documenting this experience it has highlighted for me the ethics of undertaking autoethnographic work, specifically caring for the self. When researchers prepare to undertake qualitative work, we go through a rigorous ethics approval process to ensure the participants are well supported and protected from any potential risk of harm. While ethical consideration is extended to the individual conducting the research, self-care strategies are more difficult to develop and put in place when the person at risk is yourself. As an autoethnographer conducting research not only do I have to be mindful to apply ethical considerations to the participants of the study, but must develop a way to protect myself, and my significant others, from risk of harm (Chang, 2008; Tolich, 2010). Allen and Piercy (2005) state: “By telling a story on ourselves, we risk exposure to our peers, subject ourselves to scrutiny and ridicule, and relinquish some of our sense of control over our own narratives.” (Allen & Piercy, 2005, p. 156).

Discussion

Learning to survive

What I have shared with you are my memories: thoughts, words and physical scars that are embedded in my consciousness. Recollection is personal, biased, and my memories are tinted with fear and sadness. The road to recovery has been difficult, but I have always been a fighter and way too stubborn for this to overwhelm me. Not to mention I have an amazing husband and four incredible children who have always been my light in the darkness. Through the process of researching, reading, and searching for recovery stories, I discovered helpful websites such as “Anxiety no more” which taught me how to face my anxiety each day and
work alongside it to minimise my daily fear. I commenced Cognitive Behavioural Therapy along with walking kilometres each day, doing yoga, and complete dietary changes including giving up alcohol and caffeine. My research supervisors, my husband, my best friend and a few close colleagues listened to me without judgement only concern. Am I recovered? No. But I am on the path. I cannot say that these changes in my life have come from a positive place, but I can say that the changes are becoming a positive thing and I feel blessed to have been given this opportunity for self-discovery that may or may not have happened otherwise. I am healthy, fit and in tune with my thoughts and feelings. I now identify myself as a “Spiritual Adventurer”, exploring all that it is to be me. Whilst I am not always able to manage these overwhelming anxieties yet, I know that I am a strong, determined woman who has always faced her challenges, looked them straight in the eye and conquered them.

**What is the point if it does not make it better for other women?**

The aim of using a transformative emancipatory research design was to allow for an in depth understanding of how women experienced and understood SPT, focussing on the individual experiences and interactions with health care professionals to inform and advocate for change through the research process. A strength of using a transformative research approach can be demonstrated through the actions of the research participants (J. W. Creswell, 2007; Mertens, 2003). Following data collection some of the women who participated in the study initiated ongoing contact with the researcher via email and phone to inform of subsequent pregnancies, births and endoanal assessment outcomes. I have had the opportunity to present my research reporting on SPT, including my own experiences, at various seminars and workshops over the years. At one such seminar a physiotherapist approached and thanked me, telling me that my
presentation that first day had inspired her to specialise in caring for women who had sustained SPT and has now established a SPT clinic for women just like me.

Reflecting on the aims of my mixed methods doctoral study, one of the purposes of data collection, analysis and integration was to determine how services can be improved who provide care for women who have sustained SPT. Senior NSW health policy makers and advisors welcomed my principal research supervisor and I into a discussion to explore how the findings of my research could be used to assist with the development of guidelines to improve and support service provision. The positive response of policy advisors and policy makers from this discussion was rewarding, as during the most difficult of times when death and the peace to be found there seemed attractive to my anxious mind, one of my many concerns was that my work had been for no purpose. To transform, by using the transformative-emancipatory approach, was my initial motivation, and to have hope that my work one day, will assist with the development of guidelines to transform health services and the care that women with SPT receive, brings with it a sense of closure and, with that, peace.

To witness transformation, no matter how small, is humbling. At a research presentation forum for doctoral candidates an academic staff member came up to me. She held my hands, and looked into my eyes. “You are doing such valuable work, you are a very special person. This work must have been very challenging for you, given your personal experience”. I agreed with her, describing the challenges I faced as I was required to peel away my own coping mechanisms to immerse myself in the research. She nodded solemnly, as her eyes pricked with tears. “Twenty five years ago I gave birth. My perineum was badly damaged and the doctor said to me ‘don’t look at it, it’s all black’. And I’ve never looked, not once since that day”. She
looked back up at me and gave my hands one last squeeze, “Your work is so valuable, you are very special”. She smiled at me then walked away.

**Conclusion**

The journey as an autoethnographer is both a gift and a curse as the challenges that are faced by the researcher, as they reflect on their culturally constructed self, can be both therapeutic and damaging. While my experience has not been an easy one, in preparing this paper I realised that the hardships have been eased somewhat by the opportunity to disseminate my research with the hopes of bringing about change for women who sustain SPT and postpartum morbidities.

**Competing Interests**

The author declares that they have no competing interests.

**Authors' contributions**

HP participated in research design, data collection and analysis, design, drafting and completion of manuscript as a component of a doctoral study.

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I would like to acknowledge the women who participated in this study, who generously shared their experiences of severe perineal trauma. I would also like to acknowledge my research supervisors, family and friends who have provided endless support throughout this challenging experience.
References


7.2 Chapter conclusion

This chapter presented my experiences as an autoethnographer undertaking this doctoral study in a paper titled: ‘Autoethnography and severe perineal trauma – an unexpected journey from disembodiment to embodiment.’

This paper described unexpected emotional and physical challenges autoethnographers may face as they reflect upon their experiences and research the experiences of others, and the personal implications for myself as a doctoral candidate. In the following chapter I discuss the findings of this study in the context of the literature, and consider the strengths and limitations of this study, and recommendations for future research.
Chapter Eight: Discussion

8.1 Introduction

In this mixed methods study I aimed to explore the experiences of women who have sustained severe perineal trauma (3rd and 4th degree perineal tears) and associated morbidities, and to investigate health service provision across NSW, Australia. To achieve these aims, a meta-ethnographic synthesis examined four papers reporting on the experiences of women following perineal trauma and related postnatal morbidities. Twelve women participated in one-to-one interviews with the aim of exploring how women experience and understand SPT and any associated symptoms, and how women describe interactions with health care providers and health services. Concurrently, a linked data population based cohort study examined perineal outcomes for women who gave birth in New South Wales between January 2000 and July 2008 recorded in the Midwives Data Collection (MDC), to determine if there had been a change in incidence in SPT over this time period. These births were then matched to Admitted Patient Data Collection (APDC) to determine the number of, and reasons for, any subsequent hospitalisations to quantify the burden of morbidities in women following SPT. Finally a discussion group was held with 14 CMCs from NSW with the aim of describing current health services provided to women in NSW who have experienced SPT from the perspective of CMCs. In addition a survey was also distributed to these participants to provide a further understanding of health service provision in NSW.

In the following discussion I integrate the key findings of each stage of this study as reported in Chapters Three to Six. One key overarching theme, *The Abandoned Mother*, is discussed in detail in this chapter. In addition, the contribution of autoethnography to transformative
research is explored. Finally, the strengths and limitations of this study are explored, including recommendations for future research.

8.2 Study findings – an overview

Following synthesis of the key findings from the qualitative stages of this study (Chapters Three, Five and Six) it was apparent that the way women were cared for during their pregnancy, birth and postpartum period had a direct influence on their capacity to understand and process their experience of SPT. Both positive and negative experiences influenced their ability to manage any ongoing symptoms and related morbidities. These key findings are reflected in the first theme from the publication in Chapter Five: ‘The Abandoned Mother’. This concept of abandonment appeared across all stages of the study, and these findings are discussed under the four subheadings presented in the table below: ‘Birth and the suturing process’, ‘The postnatal period, ongoing morbidities, and treatment pathways’, ‘Emotional impact and view of self’, and ‘Subsequent pregnancies/mode of birth’. The subheading ‘Gold standard care’ is representative of the findings reported in Chapter Six, and is also discussed as recommendations for future practice. Table 2 presents a summary and integration of these key findings and themes.
Table 2: Summary and integration of key findings and themes

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<td>More likely to have related surgical procedure (particularly in private system)</td>
<td>The Abandoned mother - &quot;If only they had told me&quot;</td>
<td>&quot;A patchwork of policy and process&quot;</td>
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<td>Emotional impact, view of self, and relationships with others</td>
<td>I am broken and a failure</td>
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<td>The practicalities of the unpredictable perineum</td>
<td>Less likely to have subsequent baby</td>
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Gold Standard Care
8.3 The Abandoned Mother

The most significant finding of this study is that women who sustain SPT feel a sense of abandonment, and that these feelings of abandonment appeared to occur as a result of how they were treated by health professionals during the birth, suturing process, and postpartum period. The shift of focus at the time of birth from the wellbeing of the woman to her newborn baby exacerbated these feelings of abandonment. The majority of women who experience postpartum morbidities as a result of SPT, such as urinary or faecal incontinence, describe how they are dismissed by health professionals as they attempt to seek help to manage their symptoms. Being dismissed and disregarded contributes to women feeling abandoned. Similar findings have been reported throughout the literature on birth trauma (Beck, 2004; Fenech & Thomson, 2014).

Birth and the suturing process

The findings of this study have shown that despite the reported increase in the incidence of third and fourth degree perineal tears across NSW, the majority of women interviewed for this study were dissatisfied with their interactions with health services and health professionals. How women are cared for can lead to women feeling vulnerable, disempowered, and alone, and can impact upon their long term physical and psychological wellbeing. These feelings of vulnerability and disempowerment, particularly during the birth and suturing of the perineum, are reinforced by the dismissive attitudes of health professionals as the women try to cope with and understand their experience (Priddis, Schmied, & Dahlen, 2014). As described in Chapters Three and Four, memories of being dismissed, devalued and “feeling like a piece of meat” negatively influenced the birthing experience for women (Priddis, Schmied, & Dahlen, 2014).
Similar findings are reported in research exploring women’s expectations and experiences of childbirth (O’Reilly et al., 2009; Salmon, 1999).

**Compassionate care**

Research suggests that health professional education and training is focused more on technical skill, and less on providing compassionate care to women, particularly when undertaking perineal assessment and repair (D Bick et al., 2012; Priddis, Schmied, Kettle, Sneddon, & Dahlen, 2014). This is reflected in the findings of this study. While the CMCs were more focussed on the technicalities of perineal repair and the most appropriate health professional to undertake the task, the women were less focused on the process of the repair itself. Women were more concerned with how they were cared for, and whether the actions of the health professional undertaking the repair was appropriate, such as their facial expressions and how they spoke to the women (Priddis, Schmied, Kettle, et al., 2014). The experience of suturing was described by the majority of women as a traumatic experience. Negative experiences associated with perineal suturing are explored by Salmon (1999) who describes how women felt they were being ‘patched up’ and that the suturing experience was like being ‘tortured’ (Salmon, 1999, p. 252).

The medical model of maternity care tends to focus on the skill development of health professionals to ensure the physical wellbeing of mother and baby; the emotional wellbeing of the woman is less considered (D Bick et al., 2012; Jackson, Dahlen, & Schmied, 2012). It has been argued that the existing model of medical care views the mind and body as distinct from each other, with the body functioning as separate parts (Davis-Floyd, 2001; Leder, 1984; Priddis, Schmied, & Dahlen, 2014). This approach is demonstrated in a study conducted by East et al (2014) examining the perceptions of health professionals practices for perineal
management during the second stage of labour, with one participant stating: “One can never
tell how a perineum will behave, therefore be poised, prepared and patient.” (East, Lau, & Biro,
2014, p. 12). This statement describes the perineum as separate to the total physical and
emotional form of the birthing woman, and demonstrates the medical separation of mind and
body.

Research has explored how the separation between mind and body, seen in maternity care,
contributes towards the disconnection and disembodiment some women may experience at
birth, particularly women who sustain SPT (Salmon, 1999; Young, 1984). The women who
participated in this study, were able to clearly recall the moment of birth, and when they were
aware that they had sustained damage to their perineum (Chapter Five). At the moment of birth
a woman experiences a physical and emotional opening of the self to the other as the baby and
placenta are born, a loss of the boundaries between internal and external occurs (Lupton &
Schmied, 2013; Priddis, Dahlen, Schmied, et al., 2013). While research suggests that childbirth
is a “conclusion”, where women undergo a transition to a new self, for women who sustain
SPT there is a continuation of this physical trauma through the perineum that distorts the
boundaries of the known body (Lupton & Schmied, 2013; Young, 1984). For women who
experience ongoing urinary, flatus and/or faecal leakage, the boundaries between the internal
and external are permanently altered, challenging both physical and emotional closure for
women.

In this study, it appeared that when midwives and doctors connected with, and were ‘present
for’ the women, providing them with compassionate care, women appeared to be more
connected to the experience and more aware of their bodies; they asked more questions and
followed up on any concerns in the postnatal period. During labour, birth and the postpartum
period, studies demonstrate that women value the supportive presence of their care providers, which facilitate feelings of safety, control, and trust (Beck, 2004; Gibbins & Thomson, 2001; Halldorsdottir & Karlsdottir, 1996). The concept of compassionate care is explored in nursing literature, and can be described as the ability of the health professional to fully commit to the experience of the person they are caring for, establishing and developing a connection that assists the health professional to feel empathy towards the experiences of the other (Burnell, 2009; Roach, 2007). Tavernier (2006) explores the concept of compassionate care, relating empathy to “presence” and defining presence as: “…the mutual act of intentionally focusing on the patient through attentiveness to their needs by offering of one’s whole self to be with the patient for the purposes of healing” (Tavernier, 2006, p. 154). The author describes that, when health practitioners are completely present it facilitates increased feelings of trust and safety that result in positive physical and psychological outcomes for the person within their care as they feel understood, safe and in control due to the “presence” of the practitioner (Tavernier, 2006). In maternity care, Wagner (2001) describes the importance of compassionate care as ‘humanizing birth’, stating that:

...respecting the woman as an important and valuable human being and making certain that the woman’s experience while giving birth is fulfilling and empowering is not just a nice extra, it is absolutely essential as it makes the woman strong and therefore makes society strong. (Wagner, 2000, p. S25).

The value of presence and support in midwifery is described by Schmied et al (2010) in a meta-synthesis exploring breastfeeding support for women in the postnatal period. In the findings, the authors use the term ‘authentic presence’ which describes a relationship between a woman and her care provider, based upon trust, where the woman feels supported and valued (Schmied, Beake, Sheehan, McCourt, & Dykes, 2011, p. 51). Similar findings are reported elsewhere
(Burns, Fenwick, Sheehan, & Schmied, 2013; Fenwick, Barlcay, & Schmied, 2008). However, task oriented health care systems, and inadequate staff to patient ratios, present challenges for health professionals in providing holistic, compassionate care (Hall, 2013; Tavernier, 2006; Wagner, 2000). Hall (2013) suggests that when midwives continue to work in challenging work environments they may reach a point of exhaustion, or become ‘burnt out’, and consequently be unable to provide ongoing compassionate care (Hall, 2013). In addition, research has examined the experiences of midwives caring for women who sustain SPT. Studies report that midwives may feel a sense of guilt, and that they have failed the woman they are providing care for, associating SPT with a lack of professional wisdom and skill as a midwife (Edqvist, Lindgren, & Lundgren, 2014; Lindberg, Mella, & Johansson, 2013).

Guidelines and classification of perineal trauma

The findings of this study demonstrate that the services provided reflect a ‘patchwork’ in the provision of care for women who sustain SPT in NSW. This patchwork is evident in the variations in policies and guidelines for providing care for women who sustain SPT, including the location and methods of repair of SPT, inconsistencies in the minimum qualifications and training required for the health practitioners who perform repair of SPT (Chapter Six). The lack of focus in the health system to support women who sustain SPT and ongoing morbidities contributes towards the abandonment of women in the postnatal period.

This ‘patchwork’ of services has been explained previously, by the variation in the classification and repair of SPT, the education and training of health practitioners in perineal repair and their level of confidence, and whether or not SPT is seen as a reportable incident (Best, Drutz, & Alarab, 2012; D Bick et al., 2012; Thiagamoorthy, Johnson, Thakar, & Sultan, 2014). A questionnaire based audit of maternity services in the UK conducted by
Thiagamoorthy et al (2014) aimed to determine variations in incidence and obstetric management of SPT. The audit was in response to the ‘Maternity Dashboard’ released by the Royal College of Obstetricians and Gynaecologists in 2008 (RCOG) which presented a benchmark standard of performance for maternity units; the incidence of SPT (third degree tears) and subsequent management was included as one of the performance standards (RCOG, 2008). The authors report that classification of SPT according to the RCOG perineal trauma classification guidelines (3a, 3b, 3c or 4th degree) was used by 86% of low risk units, with only 55% of high risk units adopting this classification guide (RCOG, 2007). Based upon the variation in classification standards, the rate of SPT across the UK was reported to range from 0 – 8%, with a median rate of 2.9% (Thiagamoorthy et al., 2014). Higher rates of SPT were experienced by primiparous women in comparison to multiparous women (6.1% versus 1.7%). These findings reflect those reported by Dahlen et al (2013) (Appendix A). However, the authors caution that due to the variation in the classification of perineal trauma reported in the study, the rate of SPT may reflect this variation in diagnostic and classification practices (Thiagamoorthy et al., 2014).

A variation in classification procedures as described by Thiagamoorthy et al (2014) is reflective of a lack of national and international classification, diagnostic and repair guidelines for perineal trauma despite the increasing incidence of SPT (Edozien et al., 2014; Thiagamoorthy et al., 2014). According to the findings of this study, the majority of health services across NSW use the guideline developed by the Royal College of Obstetricians and Gynaecologists (RCOG, 2007) that is specific to the classification, diagnosis and treatment of severe perineal trauma. International guidelines which make reference to immediate care following SPT, are the National Institute of Clinical Excellence (NICE) postpartum guidelines, and the guideline
from the Society of Obstetricians and Gynecologists of Canada (SCO) “Operative birth and antibiotic prophylaxis following obstetric procedures” (National Institute for Health and Care Excellence, 2006; Society of Obstetricians and Gynaecologists of Canada, 2010). The lack of guidelines prioritising the care of women who experience SPT, and the lack of implementation of existing guidelines in healthcare services, is indicative of the ‘patchwork’ approach as described in Chapter Six.

The postnatal period, ongoing morbidities and treatment pathways for women who sustain SPT

In Australia, postnatal support is most often provided by a midwife, the average length of care varying from two to ten days, to up to six weeks (J. Henderson, Hornbuckle, & Doherty, 2007). This variability in the provision of postnatal care exists on both a national and international scale (Schmied & Bick, 2014). There are many benefits reported for the health and wellbeing of both the woman and her newborn when education and support in the postnatal period is provided (Persson, Fridlund, Kvist, & Dykes, 2010). A study conducted by Persson et al (2010), described that new mothers feel more secure and prepared in their first postnatal week when they were provided with guidance on where to seek support following discharge (Persson et al., 2010). However, research reports that women are often dissatisfied due to a lack of information and educational support in the postnatal period, particularly around breastfeeding and maternal health issues (S. Brown, Small, Faber, Krastev, & Davis, 2005; Fenwick, Butt, Dhaliwal, Hauck, & Schmied, 2010).

In this study I found that, despite the significant morbidities women may experience as a result of SPT, the majority of participating professionals or CMCs reported inconsistencies in treatment pathways for women who sustain SPT due to a lack of policies and protocols supporting consistent care (Priddis, Schmied, Kettle, et al., 2014). It is reported that perineal
assessment and repair performed by inadequately trained staff can result in inappropriate treatment, resulting in women experiencing symptoms and associated morbidities (Andrews et al., 2006; Faltin et al., 2005; Fernando et al., 2010). This study reports that women who experience morbidities following SPT are significantly more likely to require an associated surgical procedure (vaginal, rectal or anal repair following initial repair, fistula repair, and urinary and/or faecal incontinence repair) (Priddis, Dahlen, Schmied, et al., 2013); these morbidities are associated with increasing national health care costs and litigation (S Brown, Gartland, Perlen, McDonald, & MacArthur, 2014; C. Henderson & Bick, 2005; C Kettle, 2005).

In addition, when women are not given information as to the degree of perineal trauma and the symptoms associated with postpartum morbidities, they are less likely to differentiate between what symptoms are normal and not normal following the birth, and consequently are less likely to seek follow up care; as a result they ‘fall through the gaps’ (Priddis, Schmied, & Dahlen, 2014). Research conducted into help seeking behaviours of women who experience postpartum morbidities, including urinary and faecal incontinence in the first year following childbirth, indicates that many women who experience these symptoms do not seek support from health professionals (Mason, Glenn, Walton, & Hughes, 2001). A prospective cohort study by Brown et al (2014) reports that women who experience urinary and/ or faecal incontinence in the 12 months following childbirth are unlikely to seek support from health professionals. However those who describe their symptoms as moderate to severe would seek support from their local GP or child and family health nurse (S Brown et al., 2014). In addition, Brown et al (2014) reports that the lack of attention paid by health professionals to maternal health in the postpartum period means that women are less likely to disclose incontinence issues. The
authors suggest that this is indicative of fragmented postpartum care resulting in an inadequate surveillance of maternal health (S Brown et al., 2014). This is consistent with existing literature exploring the shift in the postpartum period to the wellbeing of the newborn and the consequent lack of focus afforded to women who experience postpartum morbidities (D. Bick et al., 1997; O'Reilly et al., 2009; Woolhouse, Gartland, Perlen, Donath, & Brown, 2014).

*Emotional impact and view of self*

The women who participated in this study described the physical and psychological impact of sustaining SPT and the associated morbidities, and how their birth and postnatal experiences influenced the way they perceived themselves as women, wives and mothers (Priddis, Schmied, & Dahlen, 2014). Similar findings are reported in research describing the experiences of women who sustain birth related trauma, not only influencing the way women see themselves, but the impact the birth trauma has on their intimate relationships with their significant others (Elmir et al., 2011; O'Reilly et al., 2009; Salmon, 1999).

In this study, women who experienced birth related trauma felt isolated and alone; these feelings appear to occur as a result of the morbidities that impact on their daily living activities, such as the fear of experiencing an unexpected episode of urinary and/or faecal incontinence (Priddis, Schmied, & Dahlen, 2014). Elmir et al (2012) describes a sense of isolation that can occur due to women believing that their experiences are uncommon and, therefore, not able to be understood by others (Elmir, Jackson, Schmied, & Wilkes, 2012). Self-imposed isolation and attempts at concealment by women, such as minimising their daily activities to reduce the risk of experiencing incontinence in public, reinforces the notion that postpartum morbidities such as SPT are uncommon, as women are not sharing their stories and experiences with others (Kirkham, 2007; Tucker, Clifton, & Wilson, 2014). Research by Tucker et al (2014) describes
that women who experience anal incontinence as a result of SPT, remain silent as a method of self-preservation, and as a way of ‘maintaining their projected roles in society’. However this silence perpetuates the shame that women experience (Tucker et al., 2014, p. 379). Additional reasons that women do not seek support for symptoms associated with SPT, include fear of diagnostic assessment and treatments, shame and embarrassment (S Brown et al., 2014; Mason et al., 2001; Priddis, Schmied, & Dahlen, 2014).

It could be suggested that the lack of focus afforded to postpartum morbidities by health services reinforces the insignificance, and in turn normalises, the morbidities experienced by women. An example of this is reported by Brown et al (2014) who found that women described urinary and/or faecal incontinence in the postpartum period as being a minor inconvenience, despite some women reporting that they managed their lifestyle to manage signs of incontinence, that they wear incontinence pads, and drink less fluid to minimise leakage (S Brown et al., 2014).

The emotional impact that some women may experience following SPT is also seen in research exploring mental health disorders as a result of childbirth, including anxiety, depression and posttraumatic stress disorder (PTSD) (American Psychiatric Association, 1994; Beck, 2004; Fenech & Thomson, 2014). A prospective study conducted by Garthus-Niegel et al (2013), examining the etiology of post-traumatic stress symptoms following childbirth, reports that the women’s subjective birth experiences, such as how they are cared for during the birth and immediate postnatal period, is indicative of the development of postpartum stress symptoms, including posttraumatic stress disorder (PTSD) (Garthus-Niegel, von Soest, Vollrath, & Eberhard-Gran, 2013). Similar findings have been reported by Ayers (2004), Beck (2004), and Creedy et al (2000). According to the American Psychiatric Association (2014), PTSD is
triggered as a result of “…exposure to actual or threatened death, serious injury or sexual violation. (American Psychiatric Association, 2014, p. 272), and recognises childbirth as a potential trigger for the development of PTSD (American Psychiatric Association, 1994). The association between childbirth and trauma is reflected in this study, which found that, irrespective of whether or not women experienced symptoms as a result of their perineal trauma, the care they received from their care providers during this time impacted on their emotional wellbeing (Priddis, Schmied, & Dahlen, 2014).

Subsequent pregnancies/mode of birth

There is a debate in the literature as to the most appropriate mode of birth for women who have previously sustained a third or fourth degree perineal tear, with research focusing on the risk of subsequent perineal trauma and potential morbidities (Baghestan, Irgens, Bordahl, & Rasmussen, 2011; Edwards, Grotegut, Harmanli, Rapkin, & Dandolu, 2006; Elfaghi, Johansson-Ernste, & Rydhstroem, 2004). As reported in Chapter Four, this study found that women who sustained SPT in their first birth, were no more likely to experience a subsequent third or fourth degree perineal tear when compared to a woman who had no history of SPT (Priddis, Dahlen, Schmied, et al., 2013). However, studies investigating the risk of recurrence of SPT in subsequent births vary widely (Edwards et al., 2006; Scheer, Thakar, & Sultan, 2009). Studies reporting increased risk found that the risk of recurrence of SPT was associated with episiotomies, shoulder dystocia, and birth weight greater than 3500 grams (Lowder, Burrows, Krohn, & Weber, 2007; Scheer et al., 2009).

As reported in Chapter Four, women who sustain SPT with their first birth, in comparison to women who did not sustain SPT, were significantly less likely to experience a subsequent pregnancy and birth (56% versus 53%) (Priddis, Dahlen, Schmied, et al., 2013). This supports
findings previously reported by Elfaghi et al (2004) and Baghestan et al (2011). When considering subsequent pregnancies and births, a number of the women who participated in this study valued the ability to give birth vaginally and hoped for a subsequent vaginal birth. The majority of the women however reported feeling anxious and fearful at the thought of experiencing subsequent perineal trauma, and indicated at the time of the research that they would consider not having more children due to this fear. This corresponds with similar research exploring women’s experiences of SPT and subsequent birthing patterns (Salmon, 1999; A Williams, Herron-Marx, & Knibb, 2005).

The findings of the data linkage study show that, of those women who did go on to experience a subsequent pregnancy and birth following SPT, there was no difference in birth outcomes (caesareans without labour, caesareans after labour, vaginal births) when compared to women who had not previously sustained SPT (Chapter Four) (Priddis, Dahlen, Schmied, et al., 2013). The advice and recommendations given to women preparing for a birth following SPT varies (Baghestan et al., 2011; Edwards et al., 2006; RCOG, 2007). The discussion group findings indicate that, while some services provide counselling for women who have sustained SPT who are identified in the antenatal period, the mode of subsequent birth is often dictated by the preference of the practitioner, irrespective of whether the woman is symptomatic (Chapter Six) (Priddis, Schmied, Kettle, et al., 2014). These inconsistencies are representative of a ‘patchwork’ system, resulting in women not being adequately counselled postnatally or identified to receive appropriate support in the antenatal period of subsequent pregnancies; as a result these women are consequently abandoned in the system.

*Reflections from the researcher: Autoethnography using a transformative emancipatory approach*
When using a transformative emancipatory framework the contributions and opinions of the participants are valued in the research design. The women who participated in the study were advised, at the time of the interview that any papers produced as a result of the research would be made available to them to read to ensure true representation of their stories, and that feedback was welcome. Three of the women expressed interest and read the published papers presented in Chapters Three and Five of this thesis. The general feedback was that the women felt that their stories were well represented, and that it was reassuring that others had similar experiences to them, making them feel less alone. It was also suggested, as a result of the interviews, that an online support group be established to connect women who have sustained SPT, to provide an opportunity for confidential support in a mode of contact determined by the women.

As explored in Chapter Seven, I experienced many challenges as a researcher using an autoethnographic approach. There is vulnerability in sharing a personal story such as this, a story that is associated with a culturally defined stigma. Allen and Piercy (2005) describe the paradox of the journey of autoethnographers:

> By telling a story on ourselves, we risk exposure to our peers, subjects ourselves to scrutiny and ridicule, and relinquish some of our sense of control over our own narratives. Yet… a paradoxical effect occurs: By giving up the power that comes from being disembodied and disinterested observers, we can claim a new sense of empowerment and add another dimension to our understanding of the human condition. Vulnerability in return for strength. (Allen & Piercy, 2005, p. 156)

Throughout this journey, in listening to and reading literature from other specialists conducting research into perineal trauma, what I found distressing as a woman who had sustained SPT myself, and as a researcher, is the use of the term OASIS. Whilst I understand and appreciate the need to abbreviate and use acronyms, I find it somewhat offensive that the term for an
idyllic location has been adopted by specialists when referring to SPT. There is nothing idyllic, serene or beautiful about the journey travelled by women who sustain SPT, and I personally feel that to use this term reflects the dismissive attitude of health professionals and reinforces the feelings of abandonment experienced by women who seek help for postpartum morbidities.

I would like to be able to finish this thesis on a positive note, that this doctoral research journey has been one of discovery, hope, and strength as described by Allen & Piercy (2005). However, for this story, there is no happy ending. I continue to be faced with the daily challenges that I experience as a result of this research, including anxiety and depression, and I am slowly reconciling the person I once knew with this unfamiliar person I have become. The light at the end of my tunnel is that my research will help other women, and that, hopefully one day, health services will embrace and nurture women who sustain SPT as I wish that I had been.

8.4 Strengths and limitations

The use of a transformative mixed methods approach is a strength of this study, allowing for an in-depth evaluation and understanding of the experiences of women who sustain SPT, associated morbidities, and health service provision in NSW. The use of a large population based dataset, such as the MDC used in Stage 2(b), is a strength of this study due to the size of the available dataset, and the confidentiality afforded to those within the dataset due to anonymity. The contribution of data from all four stages contributes to a deeper understanding of health service provision from the viewpoint of both women and midwifery leaders. This mixed methods exploration contrasts with traditional research conducted into SPT which reduces the experiences of women into “quantifiable units of analysis” (McDonnell, Lohan, Hyde, & Porter, 2009, p. 159). The synthesis of findings from both qualitative and quantitative data provided an opportunity to collect multiple perspectives around the topic of interest to
increase the depth of knowledge. As stated by Bochner (2013): “…facts don’t tell you what they mean or how they make you feel” (Bochner, 2013, p. 54).

The women who participated in this study valued the opportunity to share their individual stories with the hope of facilitating change in the health services. Further, due to the isolation that can occur as a result of the stigmas associated with morbidities that occur as a result of SPT, for the participants this research provides a safe, confidential space to share their experiences without fear of judgement. Identifying with the researcher, due to sharing the experience of sustaining severe perineal trauma, may have encouraged women to disclose more information than they might have if interviewed by a researcher who did not share a similar experience.

There are some limitations to this study. This study focused on women’s experiences of SPT in NSW, Australia; therefore women’s experiences from other states and territories, and countries other than Australia, were not studied. Non-English speaking women were excluded from the qualitative stages (but were included in the quantitative stage) as described in Chapter Five. Therefore the experiences of women from culturally and linguistically diverse backgrounds were not included. Further, women were excluded if their experience of perineal trauma was not classified as severe (third or fourth degree tear). A total of 12 women participated in the one-on-one in depth interviews (Stage 2(b) of the study), which are representative of a small sample size. The women self-selected to participate in this study to describe their experiences of SPT, therefore the findings are not representative of the experiences of all women who sustain SPT. However interviews and recruitment were continued until saturation was reached, and the sample size was deemed as appropriate.
8.5 Recommendations for practice – The development of Gold standard care

The women and the CMCs who participated in this study identified the need for change in health care provision for women who sustain SPT. Highlighted was the need for consistency and standardisation of assessment, repair and ongoing care for women, particularly those who experience long term morbidities (Priddis, Schmied, Kettle, et al., 2014). The women in this study focused on the importance of compassionate, considerate care, particularly during the suturing process, with a clear exchange of information and consideration for their first moments with their newborns. One example of introducing compassionate, considerate care into the health care setting is ensuring that a woman and her newborn remain together during the perineal examination and suturing process both in the birthing room and in theatres.

The value of consistent care by a known care provider, based upon the exchange of information, was valued by the women in this study. The use of the term ‘trauma’ for example in SPT is often used to describe physical harm, however the findings of this study has demonstrated that trauma can encompass both physical and psychological harm. To address these needs, the CMCs described the value of establishing multi-disciplinary perineal support clinics to provide collaborative care for women, with known care providers. This model is supported in the research, reporting positive outcomes from both the view of health professionals and women (Thakar & Sultan, 2007; A Williams et al., 2005). Further research into the provision of care for women who sustain SPT is needed to inform the development of existing health services, and to assist with establishing multi-disciplinary collaborative clinics. In addition, there is a need to address the economic impact of providing care for women who sustain morbidities as a result of SPT as reflected in increasing national healthcare costs (Brown et al., 2014; Henderson & Bick, 2005). Despite this reported increase, there is a lack of research exploring
the economic consequences in caring for women who experience ongoing morbidities, and this requires consideration.

To move towards consistency in practice, it was suggested that mandatory reporting of SPT should be implemented in Australia, along with perineal anatomy and training programs for health professionals, and an associated credentialing system be implemented to ensure accurate identification and repair of all cases of SPT. During the training process, a focus should be placed on the importance of communication between the care provider and the woman during the assessment and repair process. The importance of communication can be demonstrated for example by the use of the term OASIS, which places focus on the physical harm sustained to the perineum. However, as discussed in Chapter Seven, this terminology may be offensive to women who sustain SPT, and does not encompass the psychological implications. Health professionals need to be aware of the impact that both body language and the spoken word has on women, this includes consideration as to the terminology used to describe damage sustained to the perineum. Further, the findings of this study recommend that an in depth evaluation and audit of existing policies, protocols and guidelines is required to promote and guide consistency in practice, and to move towards state-wide guidelines to promote appropriate levels of care. However, this may have unintended consequences of making midwives and doctors feel that they are responsible for SPT outcomes, therefore appropriate mentorship and training programs should be included to support health professionals (Edqvist et al., 2014).

The aim of using a transformative research design for this study was to allow for an in depth understanding of how women experience and understand SPT, with a focus on their experiences and interactions with health care professionals to determine how services can be improved, and based on this knowledge, advocate for change. An opportunity to transform
services through this research was presented when NSW health policy makers and advisors welcomed my principal research supervisor and I to a discussion to explore how the findings could be used to assist with the development of guidelines to improve and support service provision for women who have sustained SPT. These are currently in development and I will be involved in the ongoing development and implementation.

Conducting research from an autoethnographic perspective may present many challenges for the researcher, and as described in the paper presented in Chapter Seven, these challenges may manifest both emotionally and physically. Researchers intending to use an autoethnographic perspective need to be mindful of their wellbeing throughout the research process, and those supervising and supporting the researcher may be required to provide additional support throughout the research journey. However, until the journey is embarked upon the reality of the impact may not be apparent of predictable.

8.6 Further research

Women who sustain any degree of perineal trauma, have undergone suturing and experience postnatal morbidities related to vaginal birth and perineal trauma, may have experienced birth related trauma, and as a result, wish to be included in a study. I was contacted by two women who had sustained second degree perineal trauma hoping to participate in the research; due to the specificity of this study these women were unable to be included. However, it is understood that their experiences are important, and further research is required into the experiences for women who sustain perineal trauma that is not necessarily SPT.

Although the majority of research reporting mental health disorders as a result of childbirth do not list perineal trauma as a potential factor, the findings of this study have shown the impact
that SPT may have on the psychological wellbeing of a woman and it, therefore, should be considered as a factor for further research.

8.7 Conclusion

This study has presented an insight into the experiences of women who sustain SPT during vaginal birth, and their interactions with health service providers in NSW. Despite the increasing incidence of third and fourth degree perineal trauma being reported, women describe the way that they are cared for during the birth, suturing process and postpartum period, as dismissive and disrespectful. The way that women are cared for directly influences their emotional wellbeing in the postpartum period. When women identify their birth as traumatic as a result of how they are treated, feelings of trauma can lead to disembodiment, social isolation and mental health issues.

Despite research describing the benefits of multi-disciplinary specialist clinics in supporting women who experience ongoing morbidities as a result of SPT, this study has reported that health services operate within a ‘patchwork’ of service provision with variations in guidelines and policies across the state. The findings of this study emphasise the need for the development of state-wide guidelines to encourage education and training and support for health professionals to ensure that women who sustain SPT receive informed care from compassionate care providers.
References


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Appendices

Trends and risk factors for severe perineal trauma during childbirth in New South Wales between 2000 and 2008: a population-based data study

Hannah Dahlen,1 Holly Pridulis,1 Virginia Schmied,1 Anne Sneddon,2 Christine Kettle,3 Chris Brown,4 Charlene Thornton1

ABSTRACT
Design: This was a population-based data study.
Setting: New South Wales, Australia.
Participants: 510,096 women giving birth to a singleton baby during the period 2000–2008.
Main outcome measures: Rates of severe perineal trauma between 2000 and 2008 and associated demographic, fetal, antenatal, labour and delivery events and factors.
Results: There was an increase in the overall rate of severe perineal trauma from 2000 to 2008 from 1.4% to 1.9% (36% increase). Compared with women who were intact or had minor perineal trauma (first-degree tear, vaginal graz/ear), women who were primiparous (adjusted OR [AOR] 1.8 CI [1.63 to 1.95]), were born in China or Vietnam (AOR 1.1 CI [1.09 to 1.23]), gave birth in a private hospital (AOR 1.1 CI [1.03 to 1.20]), had an instrumental birth (AOR 1.8 CI [1.65 to 1.95]) and male baby (AOR 1.3 CI [1.27 to 1.34]) all had a significantly higher risk of severe perineal trauma. Only giving birth to a male baby, adjusted for birth weight (AOR 1.5 CI [1.44 to 1.58]), remained significant, when women with severe perineal trauma were compared with all other women not experiencing severe perineal trauma. This association increased over the study period.
Conclusions: To our knowledge, this is the first time that having a male baby has been found to exert such a strong independent risk for severe perineal trauma and the increasing significance of this in recent years needs further exploration.

INTRODUCTION
Severe perineal trauma occurs in 0.5–10% of the obstetric population and can occur spontaneously during an unassisted vaginal birth or as a result of obstetric intervention such as episiotomy and/or instrumental birth.5,9 Current Australian data reports rates of 1.7%, which ranges from 1.1% in Tasmania to 3% in the Australian Capital Territory.7

Severe perineal trauma during childbirth is defined as a third-degree tear, which involves injury to the perineum involving the anal sphincter complex; or a fourth-degree tear, which involves injury to the perineum including the external and internal anal sphincter and rectal mucosa.8 There is some evidence that the incidence of severe perineal trauma may be increasing on an international scale,4 but it is unclear if this is due to better recognition and reporting or an actual rise. Severe perineal trauma is associated with maternal morbidity such as perineal pain, incontinence and dyspareunia.10–12 The
Trends and risks for severe perineal trauma

significant psychological ramifications of severe perineal trauma are under-researched. 13

Risk factors during the antenatal period associated with an increased incidence of severe perineal trauma include parity, maternal age, ethnicity and nutritional status, as well as previous experience of perineal trauma, fetal weight and abnormal collagen synthesis. 14 16

Intrapartum risk factors include fetal presentation (e.g. occipito-posterior position), epistotomy (especially midline), instrumental birth, prolonged second stage of labour, birth position and shoulder dystocia. 14 17 20

The aim of this study was to examine trends and risk factors for severe perineal trauma in New South Wales (NSW) between 2000 and 2008.

METHODS

Data sources

Birth data for the time period 1 July 2000 to 30 June 2008 of all singleton births was provided by the NSW Department of Health as recorded in the NSW Midwives Data Collection (MDC). This legislated, population-based surveillance system contains maternal and infant data on all births of ≥400 g birth weight or ≥20 weeks’ gestation. While there are around 65 hospitals represented in the data, and there are variations in severe perineal trauma rates between hospitals in the NSW maternity reports, the linked data used for this study pooled all the hospitals and we were only able to separate out public and private hospitals.

The recording of perineal status was altered on MDC in 2006. Prior to 2006, perineal status was recorded as intact/graze, first-degree, second-degree, third-degree, fourth-degree tear, epistotomy and combined epistotomy and tear. Post 2006, combined epistotomy and tear was removed. The two versions of the data were merged for the purpose herein. The data item ‘Epistotomy Yes/No’ was also utilised. The accuracy of the recording of peri-

neal status has previously been shown to have a χ2 of 0.84 and 0.82 in two separate and individual studies. 21 22

The positive predictive values of first-degree, second-degree, third-degree and fourth-degree tears have been reported as 76.6, 96.0, 72.8 and 190, respectively. For the purpose of this study, group 1—intact/minor perineal trauma includes women with intact perineal status, grazes and first-degree tears (representing no or minor damage with lower morbidity). Group 2—major perineal trauma includes women with second-degree tears, epistotomy and epistotomy and first-degree and second-degree tears. Group 3—severe perineal trauma includes women with third-degree, fourth-degree tears and epistomies with extension to third-degree and fourth-degree tears. Mediolateral episiotomy is most commonly used in Australia. Only women recorded as having a vaginal delivery were included in this study. Fetal sex and gestation adjusted percentiles were calculated using the data provided within the datasets.

Ethical approval was obtained from the NSW Population and Health Services Research Ethics Committee, Protocol No.2010/12/291.

Data analysis

Descriptive short-term and long-term morbidity associated with all types of perineal trauma was produced utilising SPSS V.19 (IBM) with contingency tables. Associate factors between groups 1 and 2 (intact/minor perineal trauma and major trauma) and 3 (severe perineal trauma) and demographic data, antenatal, labour and delivery events were analysed using logistic regression and multinomial regression techniques in a forward stepwise fashion utilising the Wald method with the inclusion of variables with a significance of p<0.01.

Frequency distributions were used to classify the population and descriptive statistics of the morbidity outcomes. Adjusted OR (AOR) was calculated between factors and events and binary logistic regression techniques were applied to potentially associated demographic, fetal, antenatal, labour and delivery events and factors and the incidence of severe perineal trauma.

The time period of the study was divided into 5-year epochs (2000–2002, 2003–2005, 2006–2008) when examining the trends in rates and associated factors for severe perineal trauma. Birth weight centiles adjusted for sex and gestation at birth were created from the data produced within the dataset. This was able to be undertaken owing to the size of the dataset and increased the validity for accurate comparisons. Statistical results were produced using SPSS V.19 (IBM). The level of significance was set at <0.001 to minimise the false-positive results in this large cohort.

RESULTS

Between 1 July 2000 and 30 June 2008, there were 510 006 vaginal births. Nearly all of these births occurred in hospital (95%) and 71% of the women were born in Australia. Of the women giving birth vaginally, 14.2% had an instrumental birth and 0.6% had a vaginal breech birth (table 1). There was a significant increase in the overall rate of severe perineal trauma from 2000 to 2008 from 1.4% to 1.9% (figure 1). This increase was most evident in the category ‘third-degree tears’ and in the percentage of women who had severe perineal trauma associated with extensions following an epistotomy. Results of univariate and stepwise regression models are provided in table 2.

Compared with women who had an intact perineum or minor perineal trauma (first-degree tear and grazes), women who were primiparous (AOR 1.8 CI (1.65 to 1.95), were born in China or Vietnam (AOR 1.1 CI (1.09 to 1.23), gave birth in a private hospital (AOR 1.1 CI (1.03 to 1.20), had an instrumental birth (AOR 1.8 CI (1.65 to 1.95) or had a male baby (AOR 1.3 CI (1.27

<table>
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<td>186310</td>
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<td>29.5 (5.51)</td>
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<td>Forceps</td>
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<td>Vaginal breech</td>
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<td>2.1</td>
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<tr>
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<td>2.2</td>
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<tr>
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<tr>
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</tr>
</tbody>
</table>

to 1.34) all had a significantly higher risk of severe perineal trauma.

When we compared women in two groups, those having severe perineal trauma with those not having severe perineal trauma, only the male sex (AOR 1.5 CI (1.44 to 1.58) remained significant (table 5). We examined the changes over three epochs and found that this trend was more significant in the last epoch than in the first (figure 2). There was no evidence of a change in mean overall birth weight over the study period time or in male birth weight over the 90th centile (figure 3). When the male sex appeared as a major risk factor for severe perineal trauma, we examined other potential associated factors including smoking. An examination of smoking in NSW over the 8-year period showed an overall decrease (4.2%; figure 4).

**DISCUSSION**

It appears that the incidence of severe perineal trauma is increasing in NSW, particularly third-degree tears. The finding that the male sex, following adjustment for weight and gestation, is an independent risk factor for severe perineal trauma is perplexing. The associated effect of the male sex also increases over the time of the study period. To our knowledge, this is the first time that the male sex has been associated with severe perineal trauma.

It is most likely a viable argument that certain features of the male fetus, such as larger head circumference and wider shoulder diameters, are somehow contributing to this effect. Patourel et al. found that risk of shoulder dystocia was higher in male infants compared with female infants regardless of birth weight. It has also been postulated that male infants produce higher levels of growth hormones that makes male infants have a more solid body mass. Differences in male and female body structure and composition (sexual dimorphism) may be a plausible explanation. Literature reports that male newborns are heavier, longer, have larger heads, wider shoulder width, chest size and body mass than females, though females have greater skin.
Trends and risks for severe perinatal trauma

| Table 2 Factors associated with severe perinatal trauma compared with intact/minor trauma |
|--------------------------------------------------|------------------|------------------|-------------------|----------------------|------|
| Age (years)                                      | Intact/minor    | Severe           | Unadjusted OR     | Adjusted OR         | p Value |
| 12–25                                            | 97.7%           | 2.3%             | 1.1 (0.99 to 1.11) |                     |       |
| 26–35                                            | 97.6%           | 2.4%             | 1.0 (0.95 to 1.11) |                     |       |
| >35                                               | 97.7%           | 2.3%             |                  |                     |       |
| Parity                                           | 97.9%           | 2.1%             |                  |                     |       |
| Multiparous                                      | 97.2%           | 2.7%             |                  |                     |       |
| Primiparous                                      | 97.3%           | 2.7%             | 1.3 (1.29 to 1.31) |                     |       |
| Cephalic delivery                                | 97.8%           | 2.3%             | 1.2 (1.05 to 1.30) | 1.1 (1.09 to 1.23)  | *0.04 |
| Other                                            | 97.7%           | 2.3%             |                  |                     |       |
| China/Vietnamese                                 | 97.4%           | 2.6%             |                  |                     |       |
| Gestational diabetes                             | 97.2%           | 2.3%             | 1.1 (0.94 to 1.20) |                     |       |
| No                                               | 97.5%           | 2.5%             |                  |                     |       |
| Yes                                              | 97.8%           | 2.2%             | 1.0 (0.85 to 1.1)  |                     |       |
| Hypertensive disorder of pregnancy               | 97.8%           | 2.2%             | 1.0 (0.85 to 1.1)  |                     |       |
| No                                               | 97.8%           | 2.2%             |                  |                     |       |
| Yes                                              | 97.8%           | 2.2%             |                  |                     |       |
| Level hospital of birth                          | 98.1%           | 1.9%             | 1.0 (0.72 to 1.67) |                     |       |
| 1                                                | 97.5%           | 2.1%             | 1.2 (0.79 to 1.77) |                     |       |
| 2                                                | 97.7%           | 2.3%             | 1.2 (0.77 to 1.71) |                     |       |
| 3                                                | 97.8%           | 2.2%             | 1.2 (0.78 to 1.71) |                     |       |
| 4                                                | 97.8%           | 2.2%             | 1.2 (0.81 to 1.79) |                     |       |
| 5                                                | 97.8%           | 2.2%             |                  |                     |       |
| 6                                                | 97.2%           | 2.8%             |                  |                     |       |
| Hospital type                                     | 97.7%           | 2.3%             | 1.2 (1.13 to 1.27) | 1.1 (1.03 to 1.20)  | 0.004 |
| Public                                           | 97.3%           | 2.7%             |                  |                     |       |
| Private                                          | 97.3%           | 2.7%             |                  |                     |       |
| Onset of labour                                   | 97.7%           | 2.3%             | 1.0 (0.97 to 1.10) |                     |       |
| Spontaneous                                      | 97.6%           | 2.4%             |                  |                     |       |
| Induced                                          | 97.6%           | 2.4%             |                  |                     |       |
| Delivery type                                     | 97.8%           | 2.2%             | 0.8 (0.59 to 1.18) | 1.6 (1.65 to 1.95)  | <0.0001|
| Normal vaginal delivery                          | 98.0%           | 2.0%             | 2.0 (1.89 to 2.16) |                     |       |
| Instrumental delivery                            | 95.7%           | 4.3%             |                  |                     |       |
| Epidural usage                                   | 97.9%           | 2.1%             | 1.2 (1.12 to 1.30) | 1.0 (0.94 to 1.10)  | 0.53  |
| No epidural                                      | 97.5%           | 2.5%             |                  |                     |       |
| Epidural                                         | 97.5%           | 2.5%             |                  |                     |       |
| Gender of baby                                    | 98.2%           | 1.8%             | 1.6 (1.50 to 1.65) | 1.3 (1.27 to 1.34)  | <0.0001|
| Female baby                                      | 97.8%           | 2.9%             |                  |                     |       |
| Male baby                                        | 97.8%           | 2.9%             |                  |                     |       |
| Birth weight centile >90th                       | 97.7%           | 2.3%             | 1.0 (0.95 to 1.12) |                     |       |
| Yes                                              | 97.7%           | 2.4%             |                  |                     |       |
| No                                               | 97.8%           | 2.4%             |                  |                     |       |

fold thickness. In the final weeks of pregnancy, male infants lose fat and gain more weight than female infants with the sexual dimorphism becoming more pronounced. This, however, does not explain why the male sex became more pronounced over time in this study, particularly in recent years, unless sexual dimorphism is changing.

Another possible explanation for the increasing impact of the male sex on severe perinatal trauma is the decline in smoking over the past decade (4.2%). A study published by Zaren et al found a negative effect on fetal growth from maternal smoking to be more marked in the male fetus than the female. This included birth weight and mean biparietal diameter measurements.

The authors conclude that an intrauterine growth velocity and a different hormonal milieu are suggested as possible explanations for the greater male susceptibility. In another study, we found that women who smoked were significantly less likely to have an admission in the year following birth for vaginal repair following primary repair, rectal/anal repair following primary repair; fistula repair and urinary/fetal incontinence repair associated with severe perinatal trauma compared with those who did not smoke. In other studies, smoking has been found to be protective against the development of pre-eclampsia.

Other factors such as more intervention during birth may also be having a subtle effect on this outcome.
Table 3 Factors associated with severe perineal trauma compared with no/all other trauma

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<th>Age (years)</th>
<th>No/all other trauma (%)</th>
<th>Severe (%)</th>
<th>Unadjusted OR</th>
<th>Adjusted OR</th>
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<td>12–25</td>
<td>98.4</td>
<td>1.6</td>
<td>1.0 (0.94 to 1.07)</td>
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<tr>
<td>26–35</td>
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<td>1.0 (0.92 to 1.07)</td>
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<td>&gt;35</td>
<td>98.4</td>
<td>1.6</td>
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<tr>
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<tr>
<td>Birth weight centile &gt;90th</td>
<td></td>
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<tr>
<td>Yes</td>
<td>98.4</td>
<td>1.6</td>
<td>1.0 (0.95 to 1.12)</td>
<td></td>
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<tr>
<td>No</td>
<td>98.4</td>
<td>1.6</td>
<td>1.0 (0.95 to 1.12)</td>
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</table>

Intervention during childbirth has increased significantly in Australia in the last decade. Melamed et al found that women carrying a male fetus were at increased risk for operative delivery for non-reassuring heart rate and failed instrumental birth. Other studies have found male sex to be a risk factor for gestational diabetes, cord complications, caesarean delivery, meconium and low Apgars. Other studies show equivocal outcomes and there is still not a clear understanding of the possible mechanisms between male sex and pregnancy outcome.

We found that the rate of severe perineal trauma had increased by 36% between 2000 and 2008 and much of this increase was associated with third-degree tears. There is evidence that the incidence of severe perineal trauma may also be increasing on an international scale, but it is unclear if this is due to better recognition and reporting or an actual rise. Reporting can vary as well when it comes to severe perineal trauma, with some studies not including extensions to third-degree and fourth-degree tears following episiotomy. We found severe perineal trauma rate to be increased between 0.5% and 0.6% when these extensions were added. Where the episiotomy rates are higher, such as in private hospitals, this may lead to a serious underestimation of severe perineal trauma rates and incorrect conclusions being drawn. While in our study there were associations between primiparity, Asian ethnicity, private
hospital birth and instrumental birth when we compared the severe perineal trauma group with the no/minor perineal trauma group, this was not seen when compared with all women not experiencing severe perineal trauma. In previous prospective studies that we undertook, a link was found between Asian ethnicity, primiparity, instrumental birth and large infant birth weight.\textsuperscript{12–40}

The apparent rise in severe perineal trauma needs to be explored further to determine whether this is an actual rise or is simply due to better identification and reporting. Studies have shown that, with increased vigilance and appropriate examination, the detection rate of third-degree/fourth-degree tears are more than doubled.\textsuperscript{6–41}

Other possible explanations for the increase of obstetric anal sphincter injuries may be related to changes in clinical practice, including reclassification of third-degree tears (Royal College of Obstetricians and Gynaecologists Green-top Guideline No 29, 2007), decreased skill in the appropriate use of episiotomy and high intervention rates in childbirth.

The significant morbidity associated with severe perineal trauma and the impact on women’s lives is still not well understood and there are limited data on women’s experiences.\textsuperscript{15–42} reported that approximately 30–50% of women who sustain a third-degree or fourth-degree tear will suffer some degree of perineal pain, chronic anal incontinence, fecal urgency and dyspareunia (Sultan et al, 1994).

There are significant advantages of using population-based datasets such as MDC, including the size of the database, the guaranteed accuracy of a validated dataset and the anonymous nature of the results therein. The limitations are the limited number of variables that are included and the scarcity of specific information on potential confounders; for example, we could not control for shoulder dystocia and occipital posterior position. We are reassured by previous validation studies, however, that perineal status is very accurately recorded.\textsuperscript{29–39} While we could control for birth weight, which appears not to have increased over the study period, we could not control for maternal body mass index, which is known to have increased.\textsuperscript{63–44}

**CONCLUSION**

There was a significant increase in the overall rate of severe perineal trauma in NSW from 2000 to 2008, reflecting observations from other studies. While primiparity, Asian ethnicity, birth in a private hospital, instrumental birth and male sex were significant risks for severe perineal trauma compared with women with no or minor trauma, only male sex remained significant when compared with all women experiencing or not experiencing severe perineal trauma. The association between severe perineal trauma and male sex has increased in more recent years and it is unclear why this might be the case. More research is needed to determine why the severe perineal trauma rate is increasing and whether there are population changes or iatrogenic influences that may be behind this.

**Author affiliations**

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3. Women’s Health Stafford, Staffordshire University, Bracolmides, UK
4. NHMRC Clinical Trials Centre Sydney, University of Sydney, Sydney, New South Wales, Australia

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**Figure 2** Statistical significance of association between male sex and severe perineal trauma by epoch.

**Figure 3** Percentage of male babies >90th centile over time.

**Figure 4** Percentage of all women and sex-specific baby rate of smoking over time.
Appendix B – Evaluation of qualitative research studies for meta-ethnographic synthesis using the CASP tool
### Supporting Information File 1

<table>
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<tbody>
<tr>
<td>1. Was there a clear statement of the aims of the research?</td>
<td>Yes. “...explore how a group of women described their subjective experiences of difficulties in the immediate post-birth period.”</td>
<td>Yes in the abstract. “The objective of this study was to explore the views and experiences of women in the postpartum period after sustaining a third-degree obstetric anal sphincter tear.”</td>
<td>Yes. “The aim of this study was to critically examine women’s experiences of enduring perineal morbidity.” The research was further based upon two research questions that are outlined in a section titled Aims and research questions.</td>
<td>Yes in the Introduction section. “...aimed to build understandings of women’s recovery experiences in the presence of continued pelvic problems extending beyond the puerperium to provide nurses and other health professionals with information to enhance current practice.”</td>
</tr>
<tr>
<td>2. Is a qualitative methodology appropriate?</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>3. Was the research design appropriate to address the aims of the research?</td>
<td>Yes – feminist methodological approach was undertaken.</td>
<td>Yes – a qualitative methodology was appropriate to this research, however it is not stated what specific qualitative methodological approach was undertaken.</td>
<td>Yes. Q methodology – according to the authors – allowed for a systematic interpretation of subjective views, drawing on both quantitative and qualitative methodological approaches. It is a five step process. It is noted by the authors however that Q methodology requires a “commitment” from the participants and while there was an initial 100% response</td>
<td>Yes – a phenomenological methodology was used, informed by in depth interviews and symbolic drawings (the symbolic drawings were not reported upon in this paper).</td>
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<td><strong>4.</strong> Was the recruitment strategy appropriate to the aims of the research?</td>
<td>As stated by author, snowball sampling may potentially attract participants with similar experiences to those already recruited</td>
<td>All women were obtained through a specialist perineal clinic in a large UK hospital therefore it would be suggested that the experiences of these women are potentially different to those who were unable to – or did not - access specialist treatment. Therefore this recruitment strategy may have introduced bias in findings.</td>
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<td>Women submitted an expression of interest to participate in an earlier project that was conducted by two of the three authors of this paper. Following on from the initial study, women were invited to participate in this research project. Therefore this method of recruitment was appropriate.</td>
<td>Yes, women were recruited by purposive sampling through a media release and distribution of brochures at childcare centres with NSW Australia. The authors identify that this method of recruitment ensured that information regarding the study was received by a broad demographic, not only women accessing ongoing health service support.</td>
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<td><strong>5.</strong> Were the data collected in a way that addressed the research issue?</td>
<td>Yes – individual unstructured interviews to enable an understanding of women’s subjective experiences of perineal trauma</td>
<td>Yes - two focus groups (total of 10 women) with women who had experienced perineal trauma. The authors discuss the benefits and limitations of the use of focus groups for this research project.</td>
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<td></td>
<td>Yes – initial data was collected using face to face semi structured interviews.</td>
<td>Yes, through individual in depth interviews which is a suitable methodological approach to address the research aim.</td>
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<td><strong>6.</strong> Has the relationship between the researcher and participants been adequately considered?</td>
<td>Not stated</td>
<td>Stated by authors in Discussion and Conclusion whereby the principal researcher was also a caregiver in the clinic however the authors state that this had</td>
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<td></td>
<td>Not stated.</td>
<td>Not stated.</td>
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<td>7. Have ethical issues been taken into consideration?</td>
<td>Yes – confidentiality ensured, pseudonyms used in article, participants advised that they could withdraw at any time. Ethical approval obtained by relevant academic institution</td>
<td>Yes, ethics approval was obtained by local research ethics committee and the UK hospital research committee. Confidentiality was ensured and interviewee quotes were de-identified in the article.</td>
<td>Yes, local ethics was obtained. Full consent was obtained. Confidentiality was ensured through coding of participant interview responses.</td>
<td></td>
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<td>8. Was the data sufficiently rigorous?</td>
<td>Yes – in depth description of process. Participants were invited to comment on and validate the transcript and emerging themes</td>
<td>Yes – there is a description of the data analysis process. Two researchers independently generated themes from the data to minimise bias. Participants were sent transcripts of the focus group to confirm accuracy and researcher interpretation.</td>
<td>Yes - The completed Q set was reviewed independently by all three authors to ensure “constructual and contextual validation”. The participant statements were reviewed by the participants and sorted into three categories (most disagree, don’t know, most agree). The data were analysed and factor weightings were calculated using PQMethod.</td>
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<td>9. Is there a clear statement of findings?</td>
<td>Yes – under three thematic headings</td>
<td>Yes - under seven thematic headings</td>
<td>Yes – under three headings or “stories”. Individual quotes were included throughout findings. Factor</td>
<td></td>
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<td>10. How valuable is the research?</td>
<td>The author describes how the findings add to current knowledge due to the paucity of literature in this area. The findings further highlight issues that require additional research and have implications on current practice.</td>
<td>The authors highlight that the findings of this research identify “a range of previously unrecognised emotional consequences…” and that these findings support the recommendations that are suggested by the authors in relation to the ongoing care of women with severe perineal trauma.</td>
<td>The authors identify that despite the limitations of small sample sizes and the potential bias that existed due to participant involvement in previous research, this research is unique in the explorative way in which long term effects following perineal morbidity have been examined.</td>
<td>The authors state that the findings have implications on current clinical practice, identifying the need to increase postnatal screening services and appropriate referral systems. They further highlight the need for increased education for childbearing women regarding the possibility of pelvic morbidities with the aim of increasing the incidence of women feeling comfortable to seek treatment.</td>
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Appendix C: Recruitment flyer for women

HAVE YOU EXPERIENCED A THIRD OR FOURTH DEGREE PERINEAL TEAR?

If so, I would love to hear your story.

Your experience following a third or fourth degree perineal tear following the birth of your baby or babies, will help with research so we can assess how the health care system can best care for all women who experience this complication following childbirth.

For further information please contact Holly Priddis (Midwife, PhD Candidate and Researcher) via email h.priddis@uws.edu.au or phone/text 0438 731 816.

All information will be treated with confidentiality and with the utmost respect.

Approved by the University of Western Sydney Ethics
Appendix D – Information sheet for women

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h.dahlen@uws.edu.au

Dr Virginia Schmied
Professor of Midwifery
College of Health and Science
School of Nursing and Midwifery
v.schmied@uws.edu.au
An examination of health services for women who have experienced severe perineal trauma (third or fourth degree perineal tears) in NSW.

INFORMATION FOR PARTICIPANTS

Introduction

Thank you for your interest in this PhD research project.

This project aims to explore the experiences for women who have sustained severe perineal trauma (third or fourth degree perineal tear) during a vaginal birth. The objective is to develop an increased understanding of the experience for women who have sustained severe perineal trauma, and examine how the current health services within NSW provide care for these women from the perspective of both the women and the services that are currently providing care.

We are interested in understanding the individual experience for women following a third or fourth degree perineal tear, their perceptions and experiences on interacting with health services in NSW.

We hope to identify key facilitators and barriers to the provision of appropriate and comprehensive care options for women who experience a third or fourth degree perineal tear in both the immediate postnatal period and long term care.

Who is conducting this research?

As the principal researcher, I (Holly Priddis), commenced this PhD project in 2011 to fulfil the requirements of the Doctor of Philosophy, within the University of Western Sydney, School of Nursing and Midwifery. I will be working under the supervision of Associate Professor Hannah Dahlen, Professor Virginia Schmied and Professor Christine Kettle (UK). Previous to commencing this research project, I have practiced as a Registered Midwife, currently run a charitable organisation for children with special needs, am a mother of four children and have personal experience of severe perineal trauma.

Who can participate?

- Women who have experienced a third or fourth degree tear sustained during a vaginal birth.
- Are over the age of 18 years.
- Resides within, and has accessed maternity and postnatal care services within, NSW only.
- May be considering, is currently experiencing, or has experienced a subsequent pregnancy and birth (either caesarean section or vaginal birth) following the third or fourth degree tear.
- May or may not be experiencing ongoing symptoms and complications as a result of the third or fourth degree tear.
What does participation involve?

If you agree to participate in this study, you will be asked to sign the Participant Consent Form. You will then be asked to provide some general information about yourself, such as your age, your current, and previous, health status, and previous birthing experience. Participation is entirely voluntary and you may decline to participate and withdraw at any time without ramification.

In order to understand your experience, it is intended that women who participate in this study will participate in a one on one interview with Holly Priddis at a location chosen by the participant. During this interview, the experiences of sustaining a third or fourth degree tear will be discussed. The interview will be recorded with an electronic device to ensure all the information is recorded accurately and without error. For some of the interviews, Holly may be assisted by Associate Professor Hannah Dahlen. This will be discussed with the participant prior to the interview, and the participant can decline at any time.

Risks and Benefits

There are no foreseeable risks associated with participating in this research. However it is understood that this is a personal and sensitive topic, therefore if at any time you experience emotional distress you will be encouraged to pause or cease the interview at any stage. If at any stage you would like to speak to someone about your feelings and experiences, the national contact number for Lifeline is 13 11 14. Your local community center is also able to offer you support. Additional information and support referrals can be put in place if required. We are unable to promise you any individual benefits from participating in this research, however it is hoped that this research will provide an insight into the current support services available for women who have experienced third or fourth degree perineal trauma, and improve the quality of care and availability of supportive services for women.

Voluntary Participation

Participation in this study is entirely voluntary. You do not have to take part in it. If you do take part, you can withdraw at any time without having to give a reason.

Confidentiality

All aspects of the study, including results will be confidential and only the above named researchers will have access to information on participants (in coded form). Your name and any additional identifying features will be removed from all documentation. The consent form and the general information about you will be kept in a separate location from the observation and interview data. The data will be stored in a locked filing cabinet at the University of Western Sydney and destroyed 5 years after publication. Individual participants and institutions will not be identifiable in any publications arising from this project.

Fundings and Costs

Participation in this study will not cost you anything, nor will you be paid. This study does not attract any funding, and any incidental costs will be covered in part by funding allocated to PhD students from the University of Western Sydney. Any incidental costs will be covered by myself.
Further Information

On completion of this PhD project, the data will be analysed and discussed with an expert panel with the aim of improving services for women who have experienced a third of fourth degree perineal tear. The findings will be written and published in Midwifery, Medical and Academic Journals both in Australia and overseas. Holly Priddis will also present these findings at professional national and international conferences. Throughout this process, all information that you have provided will remain confidential.

Please read this information sheet and be sure you understand its contents before you decide whether or not to participate. After you have read this information, the researcher will discuss it with you further and answer any questions you may have. If you would like to know more at any stage, please feel free to contact me:

Holly Priddis

mobile: 0438 731 816

email: 15973085@student.uws.edu.au
       h.priddis@uws.edu.au

PO Box 1132 Penrith BC NSW 2751.

Ethics Approval and Complaints

This study has been approved by the University of Western Sydney Health Research Ethics Committee. The Approval number is H9298. If you have any complaints or concerns in relation to ethical conduct during this research process, you can contact the ethics committee through the Human Ethics Officer, nominated as Complaint Officer (02 4736 0883 or email humanethics@uws.edu.au). Any issues you raise will be treated in confidence and investigated, and you will be informed of the outcome.
Appendix E – Consent form for participants

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h.priddis@uws.edu.au
Mobile: 0438731816

An examination of health services for women who have experienced severe perineal trauma (third or fourth degree perineal tears) in NSW.

PARTICIPANT CONSENT FORM

I, ............................................................................................................................................................
. [name]
of ...........................................................................................................................................
[address]

have read and understood the Information for Participants on the above named research study and have discussed the study with ..........................................................................................................................

I have been made aware of the procedures involved in the study, including any known or expected inconvenience, risk, discomfort or potential side effect and of their implications as far as they are currently known by the researchers.

I understand the interview will be audio-taped, and I agree to this.

I freely choose to participate in this study and understand that I can withdraw at any time.

I also understand that the research study is strictly confidential.

I hereby agree to participate in this research study.
Appendix F – Demographic sheet for women

Severe Perineal Trauma Study
Please take a few minutes to answer the following questions. Information from all participants will be combined to describe the women who have taken part in the observational study/interviews. All responses will remain anonymous.

1 How old are you? ________

2 Were you born in Australia?
   Yes 1
   No 2

3 Are you of Aboriginal or Torres Strait Islander origin? (Circle one number only)
   No 1
   Aboriginal 2
   Torres Strait Islander 3

4 In which country were you born?
   Australia 1
   United Kingdom 2
   Italy 3
   Greece 4
   New Zealand 5
   Vietnam 6
   Other (please specify on line) 7

5 How many children do you have?

6 With what child/children did you experience severe perineal trauma:

7 Was this child male/female? M / F

8 Birth weight: __________
9 What is the highest qualification you have completed? (Circle one number only)

- No formal qualifications 1
- School Certificate (Year 10 or equivalent) 2
- Higher School Certificate (Year 12 or equivalent) 3
- Trade/apprenticeship (eg Hairdresser, Chef) 4
- Certificate/diploma (eg Child Care, Technician) 5
- University degree 6

10 Are you employed?

- Yes 1
- No 2

11 What is your PRESENT marital/relationship status? (Circle one number only)

- Married 1
- Defacto 2
- Separated 3
- Divorced 4
- Widowed 5
- Never married 6

Thank you very much for taking the time to complete this survey.
Appendix G – Interview questions for women

1. With which baby did you experience a third or fourth degree perineal tear? Can you tell me about your experience?
2. Following the birth, at what stage were you told that you had sustained a third or fourth degree tear?
3. Did anyone explain to you how to care for your tear and what treatments you may require in hospital?
4. Did you have antibiotics?
5. What advice were you given when you were preparing to discharge the hospital?
6. Did you see an early childhood nurse/midwife following discharge? Was the third or fourth degree tear spoken about?
7. What symptoms did you experience that you feel were due to the tear?
8. How did these symptoms affect your ability to care for your baby? Do household chores? Go out?
9. How did this experience impact upon your relationship with your partner? How long was it before you felt comfortable to have intercourse? Was it uncomfortable?
10. What services did you access/ do you access for support or treatment of these symptoms?
11. Next babies: Have you had any more children following the third or fourth degree tear? Were these babies vaginal births or caesarean? Who made the decision to have a vaginal birth/caesarean? Were you given an episiotomy?
12. How do you feel about the support you were given in hospital?
13. Is there anything you would like health workers to know that might help them when they care for women like you? (Dos and Don’ts)
14. What do you wish you had known?
15. How do you see yourself as a person now?
Appendix H - Information sheet for CMC participants

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An examination of health services for women who have experienced severe perineal trauma (third or fourth degree perineal tears) in NSW.

Information for Health Professionals (Discussion Group)

I, Holly Priddis (Registered Midwife) commenced a PhD project in 2011 to fulfil the requirements of the Doctor of Philosophy, within the University of Western Sydney, School of Nursing and Midwifery. I am working under the supervision of Associate Professor Hannah Dahlen, Professor Virginia Schmied and Professor Christine Kettle (UK).

This PhD research project aims to explore the experiences for women who have sustained severe perineal trauma (third or fourth degree perineal tear) during a vaginal birth.
The aims and objectives are:

- To describe the physical health, psychological, and social experiences for women who have sustained severe perineal trauma.
- To determine if there has been a change in the incidence of severe perineal trauma in NSW over the past 10 years. To identify the factors associated with severe perineal trauma and the impact that severe perineal trauma has had on subsequent modes of birth.
- To describe the health services available for women who experience severe perineal trauma in NSW.
- To provide an integrated analysis of the data and outline best practice to inform services for women.

This research project aims to develop an increased understanding of the experience for women who have sustained severe perineal trauma, and examine how the current health services within NSW provide care for these women from the perspective of both the women and the services that are currently providing care.

Research Procedures

If you agree to participate in this study, you will be asked to sign the Participant Consent Form. You will be asked to participate in a discussion group which will be facilitated by Holly and Hannah Dahlen at a time and location to be confirmed. The aim of the discussion group is to collect information regarding the procedures, policies and guidelines that guide the provision of care for women who experience severe perineal trauma during childbirth concerning all services within your current portfolio. Responses will be recorded via a digital recording device and notes will be taken by Holly. Participation is entirely voluntary and you may decline to participate and withdraw at any time without ramifications.

Risks and Benefits

There are no foreseeable risks associated with participating in this research. However if at any time you experience discomfort you will be encouraged to pause or cease participation in the discussion group at any stage. We are unable to promise you any individual benefits from participating in this research, however it is hoped that this research will provide an insight into the current support services available for women who have experienced third or fourth
degree perineal trauma, and improve the quality of care and availability of supportive services for women.

Voluntary Participation

Participation in this study is entirely voluntary. You do not have to take part in it. If you do take part, you can withdraw at any time without having to give a reason.

Confidentiality

All aspects of the study, including results will be confidential and only the above named researchers will have access to information on participants (in coded form). Your name and any additional identifying features will be removed from all documentation. The consent form and the general information about you will be kept in a separate location from the observation and interview data. The data will be stored in a locked filing cabinet at the University of Western Sydney and destroyed 5 years after publication. Individual participants and institutions will not be identifiable in any publications arising from this project.

Funding and Costs

Participation in this study will not cost you anything, nor will you be paid. This study does not attract any funding, and any incidental costs will be covered in part by funding allocated to PhD students from the University of Western Sydney. Any incidental costs will be covered by Holly as principle researcher.

Further Information

On completion of this PhD project, the data will be analysed and discussed with an expert panel with the aim of improving services for women who have experienced a third of fourth degree perineal tear, to identify any gaps within practice and service provision, and assist with identification and suggestions of how such services can be improved to meet demand. The findings will be written and published in Midwifery, Medical and Academic Journals both in Australia and overseas. Holly Priddis will also present these findings at professional national and international conferences. Throughout this process, all information that you have provided will remain confidential.

Please read this information sheet and be sure you understand its contents before you decide whether or not to participate. This letter will be followed by a phone call from Holly to discuss the research with you further and answer any questions you may have. If you would like to know more prior to this phone call, please feel free to contact Holly:

Holly Priddis
mobile: 0438 731 816
email: 15973085@student.uws.edu.au
       h.priddis@uws.edu.au

PO Box 1132 Penrith BC NSW 2751.

Ethics Approval and Complaints

This study has been approved by the University of Western Sydney Health Research Ethics Committee. The Approval number is H9298. If you have any complaints or concerns in relation to ethical conduct during this research process, you can contact the ethics committee through the Human Ethics Officer, nominated as Complaint Officer (02 4736 0883 or email humanethics@uws.edu.au). Any issues you raise will be treated in confidence and investigated, and you will be informed of the outcome.
Appendix I – Consent form for CMC participants

PhD Candidate
School of Nursing and Midwifery
University of Western Sydney
15973085@student.uws.edu.au
h.priddis@uws.edu.au
Mobile: 0438731816

An examination of health services for women who have experienced severe perineal trauma (third or fourth degree perineal tears) in NSW.

PARTICIPANT CONSENT FORM For Health Professionals

I, ..........................................................[name]...............................
of.
...............................................................................[address]

have read and understood the Information for Participants on the above named research study and have discussed the study with ...............................................................................................................

I have been made aware of the procedures involved in the study, including any known or expected inconvenience, risk, discomfort or potential side effect and of their implications as far as they are currently known by the researchers.

I understand my responses will be recorded using a digital audio-recording device, and I agree to this.

I freely choose to participate in this study and understand that I can withdraw at any time.

I also understand that the research study is strictly confidential.

I hereby agree to participate in this research study.
NAME:..................................................................................................................

SIGNATURE:............................................................................................................

DATE:.......................................................................................................................  

NAME OF WITNESS:...............................................................................................  

SIGNATURE OF WITNESS:......................................................................................
Appendix J – Demographic sheet for CMC participants

Severe Perineal Trauma Study

Please take a few minutes to answer the following questions. Information from all participants will be combined to describe the health professionals who have taken part in the focus groups and expert panel. All responses will remain anonymous.

1 How old are you? _______

2 Are you of Aboriginal or Torres Strait Islander origin? (Circle one number only)
   No 1
   Aboriginal 2
   Torres Strait Islander 3

3 In which country were you born?
   Australia 1
   United Kingdom 2
   Italy 3
   Greece 4
   New Zealand 5
   Vietnam 6
   Other (please specify on line) 7

4 How many years have you been working as a health professional?
   ______________________

5. How many months/years have you been working in your current role?
   ______________________

6 Where do you work for the majority of time
   ______________________
Public Hospital [ ]
Private Hospital [ ]
Private Practice [ ]
N/A [ ]
Other [ ]

Thank you very much for taking the time to complete this survey
Appendix K – Survey distributed to CMC participants during discussion group

1. In what location are the majority of third degree perineal tears repaired?
   a) Birthing room
   b) Theatre
   c) Other

2. In what location are the majority of fourth degree perineal tears repaired?
   Birthing room
   Theatre
   Other____________________________

3. What suture material is predominantly used for severe perineal trauma repairs?
   a) Vicryl
   b) Dексon
   c) Catgut
   d) Polysorb
   e) Other____________________________

4. What method of suturing is predominantly undertaken?
   a) Overlapping
   b) End to end
   c) Don’t know
   d) Different with different practitioners

5. Who is permitted to repair severe perineal trauma?
   Midwives
   Residents
   Registrars
   Other____________________________

6. When severe perineal trauma occurs is it a reportable incident?
   Yes
   No
   Sometimes____________________________

7. Is there a follow up clinic available that women are referred to?
   a) Yes
   b) No
   If yes – is this service within hospital grounds?__________________________________________
8. Has a recent audit been undertaken on the incidence of severe perineal trauma within your area/unit?
   a) Yes
   b) No
   If Yes, in what year was the last audit__________________________

9. Do you think the incidence of third and/or fourth degree perineal trauma is rising?
   a) Yes
   b) No
   c) Unsure__________________________

10. Rank in order from 1 to 10 (1 being most significant, 10 being least significant) what you feel contributes to incidence of severe perineal trauma:
    _ instrumental birth
    _ gender of baby
    _ ethnicity of woman
    _ maternal weight
    _ maternal age
    _ parity
    _ position for labour
    _ position for second stage
    _ hands off technique
    _ episiotomy
    _ epidural
    _ model of care

11. If there was anything that you could incorporate into your service for women who experience severe perineal trauma, what would it be?
    ____________________________________________________________________
    ____________________________________________________________________
    ____________________________________________________________________
    ____________________________________________________________________

Thank you
Appendix L – Questions for Discussion Group with CMCs

1. Can you describe the guidelines you currently have in place for women who experience severe perineal trauma?
2. Who currently sutures severe perineal trauma within your area health service and where is it performed? For example, delivery ward/birth centre, operating theatre?
3. Is there any ongoing training and professional development provided for those who undertake the suturing?
4. Can you outline the immediate postpartum guidelines women with severe perineal trauma?
5. What is the advice given to women on discharge from the hospital?
6. What are the short and long term follow up procedures?
7. Do you have a referral system in place and who do you refer to?
Appendix M – Ethics Approval

UWS HUMAN RESEARCH ETHICS COMMITTEE

10 October 2011

Associate Professor Hannah Dahlen,
School of Nursing and Midwifery

Dear Hannah and Holly,

I wish to formally advise you that the Human Research Ethics Committee has approved your research proposal **H9298** “An evaluation of health services for women who have experienced severe perineal trauma”, until 30 December 2013 with the provision of a progress report annually and a final report on completion.

Please quote the project number and title as indicated above on all correspondence related to this project.

This protocol covers the following researchers:
Christine Kettle, Hannah Dahlen, Virginia Schmied, Holly Priddis.

Yours sincerely

Dr Anne Abraham
Chair, UWS Human Research Ethics Committee