Women’s experiences of recovery from childbirth: Focus on pelvis problems that extend beyond the puerperium

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Aims. This study 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 care professionals with information to enhance current practice.

Background. Trauma to the pelvic floor during childbirth is a relatively common occurrence and can include damage to structures and nerves. A significant number of women will experience ongoing physical pelvic problems resulting from childbirth that extend past the puerperium; however, little is known about the experiential aspects of recovery for these women.

Design. A qualitative, phenomenological study.

Method. Narrative data were collected during conversational interviews with 10 mothers who had sustained pelvic injury during the birth process that persisted past the puerperium. Recruitment was via media releases and brochures distributed through childcare facilities. The data was analysed using Van Manen’s thematic analysis.

Results. The themes that arose from the analysis were: ‘fearing intimacy’, ‘managing an unpredictable body’, ‘being resigned’ and ‘feeling devalued and dismissed’.

Conclusions. Pelvic injuries that extend beyond the postpartum period are distressing for women. They negatively affect women’s views of themselves and have an impact on various aspects of life including intimate relationships and social activities.

Relevance to clinical practice. Currently, postpartum care may have a focus on baby rather than mother and this focus may impede women making full disclosures of ongoing health needs arising from their delivery. Findings of this study suggest that women may have specific needs that extend beyond the puerperium, indicating a need for continued holistic assessments and extending practice to identify and support women experiencing persistent pelvic postpartum complications.

Key words: childbirth experience, midwifery, nursing, postpartum, qualitative study, women’s health

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Introduction

Trauma to the pelvic floor during childbirth is a relatively common occurrence and can include damage to structures and nerves (Uma et al. 2005). Worldwide, studies demonstrate the significance of postpartum physical morbidities for childbearing women (Schytt et al. 2005). Among the most debilitating sequelae associated with this type of injury are incontinence, prolapse, pain and sexual dysfunction (Uma et al. 2005, Herbert 2006). Indeed, many problems that persist over the first year of motherhood are because of the physical experience of childbirth, and not necessarily the demands of caring for a new baby (Albers 2000).

It has been noted in the literature that women may be reluctant to discuss some of the physical sequelae of childbirth with their health professionals (Albers 2000,
Brown & Lumley 2000). Borders (2006) suggests that many of the difficulties experienced by women remain undiagnosed because of a lack of focus on postpartum recovery. Although it is known that significant numbers of women experience continued pelvic and peri-anal problems beyond the puerperium, little is known about the experiential aspects of recovery for these women. This study 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 care professionals with information to enhance current practice.

Method
A qualitative, phenomenological study of women’s experiences following childbirth through in-depth interviews and symbolic representation via drawings was used to inform this study. For this paper, only the narrative accounts of the women’s stories will be presented, with the symbolic drawings being analysed separately. Van Manen (1997) refers to phenomenology as ‘the study of the lived experience’ (p. 9). This phenomenological study explored the experiences of postnatal women, where each experience was considered individual and self-interpreting (Minichiello et al. 2004). The methodology of phenomenology was, therefore, chosen as it allowed the researchers to address the meaning of the women’s postnatal issues as they arose and how these were experienced in their day-to-day lives (Van Manen 1997, Woodruff Smith 2003).

Participants
Recruitment
Purposive sampling was used to recruit mothers of children aged six weeks to five years, who had experienced persistent physical, pelvic problems that extended beyond the puerperium. All of the women resided in New South Wales, Australia. Both rural and suburban dwelling women were recruited to this study. Because of the desire to recruit women with children aged from 0–5 years, recruitment was via a statewide media release, and brochures distributed at three childcare facilities catering for children aged between six weeks and five years of age. These recruitment strategies were chosen because of the desire not to limit inclusion in the study to women already accessing health services. Data saturation was achieved after interviewing 10 participants.

Inclusion criteria
Inclusion criteria required that potential participants had experienced one or more of the conditions shown in the following and had given birth within the last five years.

1. Incontinence of urine
2. Pelvic pain
3. Haemorrhoids
4. Prolapse of the bladder, uterus or bowel
5. Dyspareunia
6. Anal problems – could include a tear or ulcer
7. Bowel problems – including incontinence.

Interviews
Data were obtained through in-depth interviews that were conversational in style and took approximately one to two hours, were taped and then transcribed. The interviews were used as a vehicle to explore the personal life stories of women living with long-term, postbirth, pelvic injuries (Van Manen 1997). A female health care professional experienced at interviewing women about sensitive matters carried out the conversational-style interviews. Interviews were conducted in mutually convenient and private locations. One woman was interviewed online using MSN – messenger services, one woman was interviewed over the phone and eight women participated in face-to-face in-depth interviews. Each interview lasted between 1–2 hours. The face-to-face and telephone interviews were audio taped with the women’s consent and the transcript of the MSN interview was retained for analysis.

Ethical considerations
Informed consent procedures were adhered to and each participant provided written consent prior to the commencement of the interview. The informed consent included explanation of the study including the risks and benefits, time required, procedure, measures to be taken to ensure confidentiality and anonymity. Furthermore, the voluntary nature of involvement in the study was clearly communicated to the participants who were advised that they could withdraw from the study at any time. To ensure confidentiality for the participants, pseudonyms were allocated to each woman and the interview transcripts were coded. The relevant institutional ethics committee provided ethics approval for this study.

Data analysis
Data from this study were analysed using thematic analysis, following Van Manen’s (1997) ideas of phenomenological reflection. The themes were generated by the first two authors reading and re-reading the transcribed interview narratives both separately and together, to understand the experiential
structures that made up the woman’s experience (Van Manen 1997). The approach followed by the researchers is described by Van Manen (1997) as the ‘selective or highlighting approach’ (p. 93) where the researchers read the text several times and highlighted phrases or sentences that revealed common themes among the participants. The process of reflecting on the transcribed conversations was guided by Van Manen’s (1997) four lifeworld existentials lived space (spatiality), lived body (corporeality), lived time (temporality) and lived other (relationality). Lived space refers to the context of day-to-day existence; lived body refers to the physical or bodily presence in which we reveal or conceal something about ourselves; lived time is our temporal way of being in the world, is subjective time and inclusive of the past, present and future; and lived other is the relationship we form and share with others within our interpersonal space (Van Manen 1997). Once emerging themes developed, the final two authors were consulted and a consensus around the themes was reached. This collaborative approach ensured credibility and dependability of the findings (Minichiello et al. 2004, Polit & Beck 2008).

Results

Ten women who experienced pelvic problems extending beyond the puerperium participated in this study. Participant details are presented in Table 1. Findings revealed that the women experienced ongoing difficulties that had extended up to five years postdelivery. Thematic analysis revealed four major themes. They are: ‘fearing intimacy’, ‘managing an unpredictable body’, ‘being resigned’ and feeling ‘devalued and dismissed’.

Fearing intimacy

The nature of the pelvic injuries the women experienced had affected their intimate lives with their partners. This previously enjoyable aspect of life had become complicated with unpleasant feelings of apprehension and fraught with anxiety and unease and so became an activity to be avoided. The women described experiencing fear and panic when faced with intimate contact, and resulted in avoidance of such contact with partners:

Jessica: So since the baby has been born [18 months ago] I haven’t had sex at all and I don’t see that I can foreseeably do it … If he [partner] tries to get close, it was like push him away, just not interested that’s all. I get really edgy and nervous and I just can’t deal with it.

Vaginal and perineal pain, or the fear of it, was a factor for some of the women and was the main contributory factor that had prevented the resumption of intimate contact:

Jane: There is still some pain and discomfort in the vaginal wall. But things are painful there so we haven’t had sex because of that. We have tried a couple of times but it is too painful.

Table 1 Participant information

<table>
<thead>
<tr>
<th>Pseudonym</th>
<th>Age group (years)</th>
<th>Delivery mode</th>
<th>Parity</th>
<th>Time since last delivery (at interview)</th>
<th>Persistent pelvic problem</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rachel</td>
<td>20–29</td>
<td>VD</td>
<td>1</td>
<td>Nine weeks</td>
<td>Haemorrhoids</td>
</tr>
<tr>
<td>Jessica</td>
<td>30–39</td>
<td>VD</td>
<td>1</td>
<td>Eighteen months</td>
<td>Dyspareunia</td>
</tr>
<tr>
<td>Amy</td>
<td>30–39</td>
<td>VD</td>
<td>2</td>
<td>Fourteen months</td>
<td>Dyspareunia</td>
</tr>
<tr>
<td>Beth</td>
<td>30–39</td>
<td>VD – assisted by forceps</td>
<td>2</td>
<td>Twenty-one months</td>
<td>Uterine prolapse</td>
</tr>
<tr>
<td>Donna</td>
<td>30–39</td>
<td>VD</td>
<td>2</td>
<td>Four months</td>
<td>Vaginal prolapse</td>
</tr>
<tr>
<td>Gemma</td>
<td>30–39</td>
<td>VD</td>
<td>3</td>
<td>Six weeks</td>
<td>Bowel problems</td>
</tr>
<tr>
<td>Jane</td>
<td>30–39</td>
<td>VD</td>
<td>1</td>
<td>Three years</td>
<td>Urinary incontinence</td>
</tr>
<tr>
<td>Margaret</td>
<td>30–39</td>
<td>VD – assisted by vacuum extraction</td>
<td>1</td>
<td>Four years</td>
<td>Haemorrhoids</td>
</tr>
<tr>
<td>Lucy</td>
<td>20–29</td>
<td>VD</td>
<td>1</td>
<td>Seven months</td>
<td>Recto-vaginal fistula</td>
</tr>
<tr>
<td>Nicole</td>
<td>20–29</td>
<td>VD</td>
<td>2</td>
<td>Eighteen months</td>
<td>Dyspareunia</td>
</tr>
</tbody>
</table>

VD, vaginal delivery.
Traumatic memories associated with their labouring and birthing interfered with the resumption of sexual relationships for these women. Where women had undergone extensive perineal tearing, requiring suturing, they expressed an ongoing fear of penetrative sex:

Gemma: … because I hate needles and when we tried to have sex we couldn’t because I just kept remembering the needles, the pain of the [perineal tear and suturing], and that just totally turned me off.

The loss of satisfying sexual relationships with their partners meant these women experienced feelings of failure and self-blame. Although they indicated that partners were generally understanding of their problems, and did not place sexual demands on them, the women themselves felt pressured because they were aware that their partner’s needs for intimacy were not being met:

Lucy: So from a sexual point of view that, well it hasn’t been an issue, not to him, but to me if that makes sense. Well it probably is an issue to him, but he doesn’t make it into an issue, 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.

This view of themselves as ‘broken’ was further complicated by pelvic injuries that resulted in incontinence and bowel leakage. Incontinence is more associated with old age and infirmity and this is how these young women had begun to view themselves.

Managing an unpredictable body

This theme reveals how many of the women experienced concerns around how unpredictable their bodies had become owing to their postbirth pelvic injuries. This was experienced as uncontrollable and often unexpected episodes of incontinence of urine and faeces, bladder and rectal prolapse and painful sexual intercourse:

Beth: My body is wearing out, I mean when you have had this problem [urinary incontinence] for a long-time really. I guess because it is a relatively small amount and you know you take precautions like you might wear a pad or something … and it is like an old lady thing and I don’t like to think of myself as an old lady.

This view of being broken, infirm and suffering ailments of the older people also had an effect on their ability to engage in sexual intimacy and their view of themselves as sexually desirable and healthy young women. Women with injuries, which had resulted in incontinence, were faced with managing bodies that had become unpredictable and unreliable. Such dysfunctions impacted greatly on the participants’ perception of themselves as women, making them feel old beyond their years:

Donna: My mum had a prolapse, but she was like about 50 when she had a prolapse and she had to have a hysterectomy. I didn’t really know that having a baby would cause it. I just thought that maybe when you get old, like Mum … Well at the time when it was really bad I did sort of feel, I felt like I was falling apart, like I was old beyond my years.

Their unpredictable bodies meant that previously taken-for-granted activities became difficult and resulted in the women placing restrictions on their social lives and activities. Simple day-to-day activities such as going to the gym or swimming with their children became problematic:

Gemma: Well it [urinary incontinence] kind of confuses me when it is time to go swimming, it is like, it is like I am in my costumes, I can’t wear a panty 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 … I think that is the only time I am really uncomfortable, like I like to take the kids swimming, but it is like when should I take my panty liner off?

The women attempted to manage their unpredictable bodies and reduce the likelihood that their incontinence would be exposed by avoiding certain activities, or being adequately prepared by, e.g. carrying extra incontinence products. However, even best laid plans were sometime thwarted by unexpected events:

Beth: With the haemorrhoids, because with that you can actually get leakage, so again you have to like wear a pad so you don’t get a mark on your underwear. With the incontinence, the other day I was sick and I vomited and I lost control of my bladder at the same time and it was a lot [of urine] that time … and I just felt, I don’t know what I felt, angered at that is what happened.

The management of unpredictable bodies became incorporated into the women’s everyday lives. Restrictions on even the simplest choices, e.g. the decision of what to wear, were affected. The link between such challenges and participants’ perceptions of premature ageing is apparent in the following narrative:

Jane: I tend to find alternatives, such as grandma undies the longer versions, I suppose you can say a long john, it stops you from having to wear a g-string, you can still get the nice effect without having to have the visible panty line. I tend to get not so much cross but jealous that other people can wear lovely clothing without having any issues. My wardrobe can be quite restricted.

Although acknowledging the adverse impact that their injuries have on many aspects of their life, participants also portrayed a sense of resignation that their injuries were
simply a consequence of childbirth. Participants accepted their injuries as commonplace and expressed that these difficulties had been managed by women for years – i.e. they considered their injuries a ‘women’s lot’ in childbirth. Participants referred to both health care professionals and older women accepting ongoing childbirth-related pelvic problems as normal. Jessica illuminates the misconceptions held by women surrounding physical difficulties and dysfunctions sustained during childbirth:

Jessica: 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 so, can’t you?’.

Being resigned

This theme denotes the resignation by women, both individually and collectively, in accepting the adverse sequelae of childbirth as being a normal occurrence postpartum. Underlying this theme is the focus on their babies’ health and wellbeing with the subsequent prioritisation of children over their mothers. The minimisation and acceptance of ongoing pelvic problems by the women were compounded by the needs of women being placed secondary to the needs of their babies. During the postpartum period, the focus of contact with health professionals was linked to the baby, and adaptation to the maternal role rather than the mother’s health needs. This focus prevented or delayed the women negotiating timely treatment:

Gemma: I didn’t go out much ... I just kind of kept to myself. I went to a clinic and got him [baby] weighed, but I never brought it up about my bladder, I never brought it up, I just kind of accepted it. I just thought it was private I think, I just never, I always thought ‘women have been doing it for many years, you know, they have managed so, can’t you?’.

Feeling devalued and dismissed

Participants described feeling devalued and dismissed when reporting their postpartum recovery concerns to health care professionals. This meant participants felt their health care providers were not listening to them and that their difficulties were trivialised and disregarded:

Beth: 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.

Right to the time of their participation in this study, several of the women continued to seek intervention for their persistent pelvic problems and reported feelings of self-blame for their continuing symptoms. Such dismissal of participants’ concerns potentially led to some participants seeking a second opinion. Jane describes her experience:

Jane: ...she really wasn’t listening to what I was saying so I felt that perhaps my own communication skills were not adequate. So when I went to see my second GP I made sure that I was quite clear in fact I even took a [written] script with what I wanted to say and communicate. So I felt that I wasn’t being listened to and that my concerns were minor. This discomfort and haemorrhoids probably occurred consistently for about eighteen months at that point of time I was just getting fed up. From there I actually went to a second GP in a medical centre that I had gone to and she actually had a look and said ‘they are not haemorrhoids they are skin polyps’.

The devaluing and dismissal of participants’ complaints were compounded by inappropriate or inadequate treatment options being offered. This is portrayed in Jane’s and Rachel’s narratives:

Jane: I don’t think I was taken seriously enough. It was just like ‘ok you have got haemorrhoids this is what you can do to alleviate them’. But there was no ‘If you are still having issues and you are still not receiving any comfort by these methods, try these methods’. Adequate alternatives were not provided.

Rachel: I was a bit disappointed that the obstetrician didn’t give me any more advice...and I do need to get a bit more help as what I am doing isn’t enough and I don’t know what else I can do.

Inappropriate comments from health professionals were reported by participants. These comments served to both devalue the women’s experiences and dismiss their foremost concerns. Jessica, who inadvertently had part of her labia sutured together after sustaining a third-degree tear, describes the response to her complaint by her doctor:

Jessica: Even the jokes you know, even my own doctor, 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’. Beth also reported inappropriate response from a health care professional when seeking treatment for her haemorrhoids:

Beth: With the first baby I did actually go back to the doctor and said ‘Look I am still not very happy’ and the response from the doctor ‘Yeah, well it is never going to be the same bottom again’ and that was the response.

As a result of not being listened to and feeling that treatment options offered were not adequate, participants were often required to repeat their story multiple times in an effort to be
hearing. In fact, at the time of the interview, some participants were still attempting to avoid themselves of adequate intervention for their pelvic injuries:

**Donna:** I didn’t really feel that the first Doctor sort of, like they are always saying do your pelvic floor exercises, I didn’t really feel like that was [enough]. Well because she didn’t really diagnose me and tell me exactly what was going on, I didn’t really feel like she had given me a solution. That is why I went to the second GP.

Self-blame was evident throughout analysis as an important aspect to this theme and was presented by women expressing their problems as being within their control. This often arose from information given to them by health care professionals:

**Beth:** I guess I keep thinking that it is me and I guess I really have thought Oh well, I did find the physio helpful after the first birth so I thought well you know what to do so just do it. For me it is also in the back of my mind not being able to do it [pelvic floor exercises] properly and not noticing any change and not getting a sense that it [incontinence] is getting any better but then the other side of me says that is because you are not doing it enough. It comes back to the fact that you have to use it or lose it and I guess I have chosen to lose it.

**Discussion**

Persistent physical pelvic problems in the postpartum period are poorly acknowledged by health care professionals and society. The experiences of the 10 women in this study identified physical pelvic problems consistent with those commonly found within the literature, including dyspareunia, urinary and faecal incontinence, perineal pain and haemorrhoids (Cheater & Castleden 2000, Doran et al. 2001, Borders 2006). However, this study also provides insights into the actual experiences that the women have had in living with such problems and reveals difficulties in achieving correct diagnosis and timely treatment. The low priority given to postnatal issues by health providers intensifies such difficulties (Albers 2000). Indeed no statewide policies related to routine postpartum care for women beyond a six-week check-up exist in New South Wales (Australia). Such policies and procedures exist purely on a local level such as individual early childhood services that focus primarily on the needs and care of infants. Postpartum women will visit their obstetrician, midwife or general practitioner for the universal six-week postnatal check-up. However, although new mothers may well continue to frequent health centres, and see health practitioners to ensure the wellness and development of their babies, little attention is directed towards the mother herself. This may impede timely invention and support for women with persistent pelvic injury.

The detrimental effects of postpartum pelvic injury to marital and sexual intimacies are revealed in this study. Intimacy and postpartum sexual intercourse are poorly addressed by health care professionals in general. Resumption of sexual intercourse after childbirth has been well researched with the literature revealing sexual avoidance related to traumatic events during childbirth, anxiety, apprehension and sexual difficulty (Thompson et al. 2002, Bailham & Joseph 2003, Figuers et al. 2003, Williams et al. 2005). Many of the participants in this study reported feelings of inadequacy in their ability to be intimate and to resume full sexual relations with their partners. At times, this resulted in detrimental effects to the relationship and/or the woman’s self-esteem.

When trying to manage their unpredictable bodies, women described feeling old before their time and challenged by the daily issues of having to live with their problems. Things taken for granted by most, have become daily challenges for these women. Several reported needing to wear absorbent pads at all times to manage their incontinence and this interfered with activities such a swimming, and gym work. Choices in what to wear became limited, and social activities presented constant difficulties. These results are consistent with the literature (Mason et al. 1995, Salmon 1999, Fitzpatrick & O’Herlihy 2005, Herbert 2006).

The invisibility of many of these problems means that health care professionals may not have full awareness of the difficulties facing some women in the postpartum period. The mother’s recovery is assumed, therefore, there is little focus on the mother. The participants in this study felt a reluctance by health care professionals to investigate maternal recovery past the six-week postnatal check-up. The women were forced either to live with their problems or seek second and sometimes third opinions. If the women were not assertive or accepted the initial health care professional’s advice, they were left to manage their problems themselves. This reluctance by health professionals was addressed by Fitzpatrick and O’Herlihy (2005) who recommended that health professionals must acknowledge that women rarely volunteer information about dyspareunia and faecal incontinence in particular and, therefore, they must directly question women. The women in this study perceived the reluctance by the health care providers to pursue their recovery problems as a sign of being devalued and dismissed.

**Limitations of the study**

A limitation of this study is that all participants fell within the age range of 25–35 years, and therefore fails to capture...
experiences of women who have persistent pelvis problems after childbirth in other age groups. A further limitation of this study is that recruitment occurred in only one Australian state. As the Australian health care system varies between states, women’s experiences of postnatal care may differ significantly. Therefore, the transferability of the findings to women residing outside New South Wales may be reduced.

Relevance to clinical practice

Findings of this study have implications for clinical practice, specifically assessment, screening and patient education. There is a need to assess the integrity of the pelvic area at the six-week check-up. This assessment should be accompanied by increased screening on postnatal women to ascertain resumption of normal activities, such as sexual intimacy, continence status and presence or absence of pain. Any difficulties in these areas could warrant further investigation and appropriate referral. The distress these women felt was compounded by their lack of awareness of the possibility of these complications. They were unprepared for the types of pelvic problems experienced. This highlights the need for effective patient education. Midwives could include education regarding pelvic complications in their routine postnatal assessment, not to frighten women but to alert them of the need to ensure that they report their concerns at the six-week visit. Had these women been told of the risks of such complications in the prenatal period, they may have felt more comfortable disclosing to their health professionals in a timely manner.

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Contributions

Study design: RO, KP, DJ, BB; data collection and analysis: RO, KP, DJ, BB and manuscript preparation: RO, KP, DJ, BB.

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