WOMEN'S EXPERIENCES OF THEIR PERINEUM FOLLOWING CHILDBIRTH: EXPECTATIONS, REALITY AND RETURNING TO NORMALITY

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Abstract

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Women's experiences of their perineum following childbirth: expectations, reality and returning to normality

The aim of the study was to explore the feelings, perceptions and experiences of women in relation to their perineum following childbirth in the early postnatal period.

A grounded theory approach was used for collecting and analysing data from eleven diaries and seven interviews with broad questions about how the perineum, following a vaginal birth, affected the way daily living activities were carried out. Initially purposeful sampling was utilised to recruit women but as important issues emerged recruitment continued through theoretical sampling.

Following childbirth women expressed a strong desire to get back to normal reflecting the core theme 'striving for normality'. Normality in this context meant doing normal things and feeling like their normal selves. Much of what the women described doing during the early postnatal period was related to achieving that goal and linked to the following categories: 'preparing for the unknown', 'experiencing the unexpected', 'adjusting to reality', 'getting back to normal' and 'recovery of self'.

The main theoretical idea that emerged from this study and derived directly from the data is that:

> If women are able to successfully adjust to their new and often unexpected reality after the birth of their baby, and begin to reclaim their selves and their world, then they experience a return to their normality.

The data demonstrates and clarifies three distinct but related aspects. Firstly, coping with the unexpected consequences of childbirth meant that the women frequently made adjustments to how they carried out essential activities such as walking, sitting and passing urine, in order to try and carry on as normal. The second aspect related to daily activities that were not essential but which women felt necessary to undertake because of social expectations. These included housework and shopping. The third aspect related to how the women felt about their body as a result of the perineal trauma they sustained, and what helped them to feel like their 'normal selves' again. These interrelated stages form a framework that reflects Maslow's lower order, hierarchy of needs, within the humanistic psychology paradigm.

Implications for practice include the need to improve care in areas of preparing women having their first baby, listening to women as part of the assessment of perineal pain following birth and the need for continuity of care from the same midwife in order for women to appropriately manage their perineal experience.

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Author's Declaration

I declare that this thesis is original material, which has not been used or published in any other study or research in the past.

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CHAPTER 1
INTRODUCTION TO THE STUDY

Introduction

During my years as a practising midwife I have become increasingly interested in the views of women and their experience of childbirth, acknowledging too that I have my own views and experience as a woman and a mother. Having the privilege to be with women during such a personal, life-changing event has taught me much about the complexities of childbirth, a richness that cannot be explained through textbooks or classroom teaching. I have been continually challenged to change the ways in which I view midwifery and my approach to practice. My interest in women's experiences has intensified since giving birth to my own children, one of whom was born during the life of this PhD. These aspects are explored in detail in chapter 9 where my personal experience of the research journey unfolds, but here, it sets the scene for this introductory chapter.

The motivation for this study arose out of the findings from my Master's Degree, where the meaning of episiotomy was explored using a critical literature review (Way 1994; Way 1998). The aim of the review was to examine the definitions, procedure, perceptions and outcomes of episiotomy in order to enhance the understanding of those health professionals who perform the procedure and the women who experience the procedure during childbirth. I found that the meaning of episiotomy is socially constructed, that is, people construct meanings from their own perspective by defining problems differently, asking different questions in order to find the same answer and drawing on their own frame of reference to define particular issues and concerns (Berger and Luckman 1984; Shilling 1993). The constructs for episiotomy were influenced by social context, professional background and personal experience. For example, one construct was that women viewed episiotomy as a medical intervention that controlled them, especially if they had not been involved in the decision-making process. In contrast, obstetricians consider childbirth as potentially hazardous and believe that women should put their trust in doctors allowing them to make what was in

their view, essentially scientific decisions. In this instance obstetricians would not see involving women in the decision-making process as important, as they knew best.

One of the recommendations from my Master's Degree was the need for midwives to understand what an episiotomy meant for women. This would ensure the support women require following an episiotomy is relevant to their needs and not based on assumptions by the medical / midwifery profession. In order for midwives to be effective in their practice, through research, midwives need to develop their own body of knowledge of childbirth from the viewpoints of those who experience it. My current research aims to contribute towards this body of knowledge by providing insight and understanding into the experience women have of a 'part of their body' anatomically described as 'the perineum' but may have had little recognition in the personal world and experience of women.

At the outset of this study several issues were considered as being significant. I wanted to ensure inclusivity in the study by providing the opportunity for women with any perineal trauma (table 1.0), whatever the cause, to be able to identify the effects it had on them. I wanted to hear the stories that women wanted to tell and I wanted to know which, if any, daily living activities such as passing urine or walking had immediate or sustained effects as a consequence of perineal trauma.

Perineal trauma is a common outcome of vaginal birth with over 85 percent of women sustaining some degree of perineal trauma (McCandlish et al 1998), and of these, approximately two thirds of women per annum will require perineal suturing (Kettle 1998). It is already recognised that the effects of perineal trauma significantly blight the experiences of motherhood for many women because of the degree of pain and discomfort experienced, and the consequent effects of this on the activities of daily living (Glazener et al 1995; McCandlish et al 1998).

Most perineal pain and discomfort is in the immediate postnatal period (Kenyon and Ford 2004; Soong and Barnes 2005), although as many as 20 percent of women have problems such as dyspareunea (painful or difficult intercourse) for at least three months afterwards (Grant 1989; Glazener et al 1995). The long-term effects of such trauma on

women's perceptions and images of their body, their femininity and their sexual attraction, remain at best uncertain and at worst unknown. Despite the high incidence of perineal trauma sustained by women during childbirth, there is with notable exception such as Kitzinger (1985; 1986) and Salmon (1999), little research that takes into account the views and experiences of women related to this phenomenon. My research is aimed at bridging this gap.

First degree tear (1^{o} tear)	A tear of the skin only
Second degree tear (2^{o} tear)	Involves the skin and the superficial perineal muscles of the pelvic floor, namely the bulbocavernosus and transverse perineal muscle and in more severe cases the pubococcygeus muscle.
Third degree tear (3^{o} tear)	In addition to the above structures there is damage to the anal sphincter.
Fourth degree tear (4^{o} tear)	This classification is sometimes used to describe trauma that extends into the rectal mucosa.
Episiotomy	Involves similar structures to a second degree tear

Table 1.0 – Medical classification of perineal tears

Maternal morbidity indicators such as severity of pain, presence of healing and absence of infection, presence of urinary incontinence, timing of resumption of sexual intercourse following the birth and any dyspareunea, are often used as predictors of outcome from perineal trauma. These indicators are usually assessed at recognised time intervals such as 24 hours, 10 days, 6 weeks and 3 months (Sleep et al 1984; Johanson et al 1993; McCandlish et al 1998). These criteria have a strong clinical focus and may not reflect what women themselves regard as being important in relation to their perineum following childbirth. The criteria reflect expected 'norms', suggesting that within certain time frames women should be sharing similar outcomes without necessarily taking into account individual factors such as previous experience and family support. The judgments that have been made to assess the degree of maternal morbidity appear to be medically led and clinically based. Inclusion of more

abstract concepts such as the birth experience and experiences with the mother-baby relationship are not included. This demonstrates a need for further research and my study responds to this need.

Currently research that is available about the consequences of perineal trauma, rarely takes into account the viewpoint and experiences of women. The approach to the research is often experimental in design (Mackrodt et al 1998; Albers et al 1999) frequently using the randomised controlled trial to frame data collection and analysis of the findings. Experimental research is a process in which various ideas framed as a hypothesis is tested and the collected data is then summarised and manipulated using statistical tests to produce numerical values.

Available literature which refers to women's experiences of perineal trauma is often anecdotal (Kempster 1987), limited by its methodology (Kitzinger 1985; Greenshields and Hulme 1993) or provides a systematic review of the current literature (Renfrew et al 1998; Hedayati 2004). Salmon (1999) currently provides the most informative piece of research on perineal trauma from the experience of women (see page 17). Kempster (1987) uses her experience as a midwife to offer a long list of distressing conditions following perineal trauma including dysuria (pain when passing urine), painful defaecation, incontinence as well as local irritation. She suggests that excruciating pain may be experienced, for example when standing, sitting, and wearing close fitting clothes, inserting tampons into the vagina or performing postnatal exercises. These anecdotal inferences indicate the importance of this phenomenon and the need for more in depth, sustained enquiry.

Kempster's study (1987) inspired the chosen daily living activities, such as passing urine, walking and sitting, that formed a crucial part of this study. They reflect what most women normally do with ease on a day-to-day basis without having given birth. I wanted to understand how giving birth could affect the ease at which women were able to continue these activities. This information would be useful in helping women to understand the impact perineal trauma may have on continuing to carry out daily living activities, and how to adjust to cope with the experiences.

Kitzinger (1985), a social anthropologist, was the first to explore women's experiences of episiotomy although acknowledging she used a non-representative sample of a cross section of childbearing women. The study is nonetheless informative about complications women can experience following this invasive procedure. For example, women who had an episiotomy with a spontaneous vaginal birth may experience more pain a week after the birth than those who had perineal tears. Some women were more likely to find it difficult to breastfeed comfortably. Kitzinger (1992a) provides further data relating to episiotomy, comparing language used by women describing their experiences of sexual abuse with women describing their traumatic birth experience and how similar language was used for both experiences. This theme is developed further in chapter 7, 'getting back to normal' where I show that some women blamed themselves for the perineal trauma they sustained. The experience women describe in the study by Kitzinger, indicates once again the necessity of further substantial enquiry.

These studies by Kempster (1987) and Kitzinger (1985) demonstrate the wealth of descriptive data that may be obtained using a qualitative approach providing access to different perspectives based on real life experiences.

Introductory literature review

In keeping with the chosen approach of inquiry, that of grounded theory, it was not appropriate to undertake a full literature review at the beginning of the research process. It is recognised that if a full literature review takes place it might lead the researcher into a specific direction rather than leave control with the participant (Morse and Field 1996; Strauss and Corbin 1998). However, a general overview of relevant literature is important to avoid the possibility of replicating studies.

It is acknowledged that the researcher will already have some background knowledge regarding the proposed research (Strauss and Corbin 1998). In respect of this study it is recognised that the researcher is a practising midwife and will therefore have knowledge about the topic being researched. Chapter 9 provides a description of the

researchers background in order for readers to determine for themselves if this has influenced the study in any way.

As part of the process for gaining ethics approval to undertake this study, an initial review of the literature was necessary in order to convince the panel that the research was appropriate and would contribute knowledge that was relevant to the study under question. This included a discussion of other researchers' work to demonstrate the need for this particular study. For the purpose of receiving ethics approval the review was relatively short showing how the study would compensate for shortcomings in previous research, justifying the chosen topic and approach.

The following section discusses some of the major issues pertinent to my research:

- Defining perineal trauma
- Indications of episiotomy
- Rates of perineal trauma

Perineal trauma is defined by Kettle (1999:1) as "any damage to the genitalia during childbirth and occurs either spontaneously or it is made intentionally by surgical incision (episiotomy)".

Until recently episiotomy, was cited as the main cause of perineal trauma with a rate of 55-60 percent of all births being achieved in the 1980s (Kitzinger 1985; Graham 1997). It is argued that the high incidence of episiotomy was dictated by the growing dominance of the obstetric profession, with a knowledge base primarily founded on a 'medical model' of care (Anderson and Podkolinski 2000). The medical model is derived from the viewpoint of the philosopher Descartes, who influenced a change in philosophical thinking about health during the 17th century. Descartes believed the Universe to be mechanistic, following predictable laws that could be discovered through science and manipulated through technology. This view differed significantly from the previous traditional or religious-based explanations of the world where members of traditional societies relied largely on folk remedies, treatments and healing techniques which were passed down from generation to generation (Giddens 2001).

Illnesses were frequently regarded in magical terms (presence of an evil spirit) or religious terms (a sin).

The mechanistic philosophy viewed nature, society and the human body as parts that could be repaired or replaced (Davis-Floyd 1990; Martin 1987). Disease came to be identified objectively by recognising symptoms and medical care by 'experts' became the accepted way of treating both physical and mental health. Davis-Floyd, a feminist birth activist, advocates that the male body became established as the prototype resulting in the female body being viewed as deviating from the male standard. This theory stemmed from the Roman Catholic belief that women were inferior to men, closer to nature and the less intelligent. The female body was then seen as inherently abnormal, defective and dangerously unpredictable, ideas which have underpinned the philosophical basis of modern obstetrics. During early medical developments in the late 19th century and early 20th century ideas about women's health were based on the understanding that the female body and female functions, such as menstruation were inherently pathological. Childbirth became placed within the medical frame of reference as a condition for which the advice of doctors was needed and hospitals became the proper place for birth. One of the assumptions based on the mechanistic approach is that the appropriate arena for treatment is the hospital, where medical technology is concentrated and best employed (Giddens 2001). A new specialisation in medicine developed, namely obstetrics and gynaecology, and the events of childbirth became best understood in purely physical and pathological terms, separating out social and emotional aspects of women's lives (Oakley 1989; Freund and McGuire 1999). Richards (1975) discusses how obstetrics grew up as a surgical specialty, which tried to solve problems by active intervention, and was based on hospital practice.

Martin (1987) explains the 'body-as-machine' metaphor in relation to obstetrics. The woman's body is the machine and the doctor the mechanic or technician who 'fixes' the machine. This explanation Martin believes, legitimises the process of intervention and takes the metaphor one step further by likening labour to a "production-line" where the doctor is the mechanic, the woman is the labourer, and the labourer's machine (uterus) produces the product (the baby). With the production-line metaphor Martin argues that obstetric intervention is a way of improving productivity. Rupturing

membranes during labour increases the performance of the uterus; accelerating the labour with oxytocic drugs ensures successful completion of labour by improving the performance of an 'exhausted uterus' and an episiotomy hastens the delivery of the final product, the baby. The impact of this medical model is developed further in chapter 3, 'striving for normality'.

By the 1980s it was suggested by Kitzinger and Walters (1981) that episiotomy had become a normal and almost expected part of childbirth for all women having their first baby and for the majority of those having subsequent babies.

The main indicators for episiotomy enshrined within the medical model at this time included (Hoult 1986):

- prevention of serious vaginal and perineal tears
- prevention of long-term problems such as stress incontinence and vaginal prolapse
- instrumental or breech delivery
- prolonged delay with the head crowning, obstructed by a tight perineum
- fetal distress where the birth of the baby is imminent
- previous episiotomy
- pre-term birth

Few of these indications were based on any research evidence (Sleep et al 1984).

Many studies of perineal trauma focus on episiotomy and have usually been instigated and led by obstetricians, therefore having a medical focus. They have primarily been concerned with the timing of performing the procedure and how to perform it (Carroli and Belizan 1999), the use of the most appropriate suture material (Mohamed et al 1989; Kettle et al 2002) and techniques to apply when subsequently repairing the perineum (Grant et al 2001; Kettle and Johanson 2000a; Kettle and Johanson 2000b). One of the first pieces of research that was led by a midwife and had a significant effect on clinical practice was undertaken by Sleep et al (1984). Sleep, a midwife returning to practice after a gap of several years, found a noticeable increase in the use of

episiotomy without any evidence to support this practice. She and her colleagues raised concerns about the routine use of this procedure questioning the indications for the procedure and noting the short- and long-term morbidity women often experience. This study used a randomised controlled approach to collect data relating to two perineal management policies, both intended to minimise trauma during spontaneous vaginal delivery. The first policy was to restrict episiotomy to fetal indications only, such as the fetus becoming distressed with the need to deliver the baby quickly. The second policy was to use episiotomy more liberally to prevent perineal tears. The consequences of the two policies were compared in terms of maternal and infant morbidity immediately after the birth and at 10 days and three months postpartum. There were no significant differences in the outcome between the two groups in neonatal state, maternal pain and urinary symptoms. Women allocated to the restricted policy were more likely to have resumed sexual intercourse within a month after birth. This work was followed up by a further study by Sleep and Grant (1987a) who identified that episiotomy did not seem to prevent urinary incontinence or decrease long term dyspareunea. This research therefore effectively challenged the existing recognised indicators for performing an episiotomy, and provided an evidence base for changing practice.

Since the completion of the work of Sleep and Grant (1987a) the episiotomy rate has been dramatically reduced from over 20 percent in the 1990s to 12 percent of births in 2003-4 (Government Statistical Service 2005). Following the publication of the study by Sleep et al (1984) and the follow up study by Sleep and Grant (1987a), the indications for episiotomy have been reviewed and updated reflecting the use of evidence to support practice (Downe 2003). Justifiable indications now include:

- prior to an assisted delivery such as forceps or ventouse extraction
- evidence of fetal compromise
- to reduce the risk of intracranial damage during pre-term and breech delivery

Since the fall in episiotomy rates it has been commented that midwives have lost the skill of maintaining an intact perineum with a consequential rise in spontaneous perineal trauma (Enkin et al 2000).

The work of Sleep et al (1984) was therefore influential in changing practice but failed to take the views of women significantly into account. These views began to be heard through studies undertaken in non-medical disciplines raising concerns relating to psychological and emotional factors as well as long-term physiological problems associated with perineal trauma. Kitzinger (1983, 1985, 1986) questioned the routine use of episiotomy in Western obstetrics and voiced concern about long-term psychosexual problems. From a sociological perspective, Oakley (1980) has written about the power struggle between women and obstetricians over the increasing use of medical intervention in childbirth and argues that studies of doctor-patient relationships have often illustrated a gap between what medicine views as legitimate knowledge and women's own personal experiences. Lay knowledge has been consistently viewed as inferior to scientific knowledge, particularly in the area of health. However, lay opinion is also becoming increasingly heard as women's voices are given a forum through pressure groups such as the National Childbirth Trust (NCT) and the Association for the Improvement of Maternity Services (AIMS). Additionally Government policy has influenced practice by placing women at the centre of care (Department of Health 1993; Department of Health 2004). With this broader interest in childbirth, the experience of women in health care appears to have become legitimised as an important area of study. This is echoed by Paterson et al (2005) when justifying the need for their study to find a valid measurement for maternal satisfaction. This view gives credence to my research in wanting to hear the voice of women in relation to their experiences of a particular aspect of childbirth.

More recently, Salmon (1999) provided an account of women's experiences of perineal trauma in the immediate post-delivery period. A lack of data on the social and psychological impact of perineal trauma on women was a prime reason for undertaking her study. Salmon also pointed out that there was no documented account of how women struggle to make sense of a very changed social identity from that of their pre-pregnant selves, or an assessment of the degree to which they feel supported by their carers in this process. She wanted to include an approach to her study that encouraged women to speak for themselves and turned to feminist sociology to achieve this. Using unstructured interviews with broad questions about experiences of childbirth and perineal trauma, Salmon concluded that one of the main implications for practice was

the importance of listening to women as a key to responsive care. A weakness of the study is the reliance on a snowballing technique to recruit the women, which tends to result in a sample of women with similar experiences and/or views. The study did however highlight the intense and far reaching effects of bad experiences of care.

The process of birth and the perineum

In order to understand women's experiences of their perineum it is first necessary to understand the function and the significance of the perineum during birth.

When a baby is born, the tissues of the vagina and external genitalia fan out. With each contraction, the head emerges little by little, acting as a smooth wedge to slowly stretch the soft tissue. The perineum thins out and the baby's head emerges over the perineum. The pelvic floor muscles, vagina and perineum have an important function in facilitating the process of birth. These structures and their functions are outlined in appendix 1.

Perineal trauma may occur as a result of tearing, cutting or stretching during spontaneous or assisted vaginal delivery. It is classified according to severity (table 1.0) but this classification does not take into account the perineum that remains intact but still causes pain due to the stretching and bruising that often occurs within the vagina and surrounding area. Although there is no apparent physical damage there may be transient pudendal or peripheral nerve injury resulting from prolonged pushing or pressure exerted by the fetal head on the surrounding structures (Allen et al 1990). Swelling and inflammation can also occur as a physiological response to the stretching and bruising of tissue and may exert pressure on nerves and tissue resulting in pain and discomfort. Women may easily notice perineal swelling, as described by Georgina:

> *"I mean when you are in the shower, I mean normally you can't actually see underneath but it's so much lower, and that's, that's a surprise as well, where it's so sort of swollen you can actually see it as well."*

Georgina had an intact perineum following the birth of her baby, but as described above, her perineum was noticeably swollen. It is because of the outcome Georgina describes and the pain and discomfort felt by other women with an intact perineum that I wanted to include this group of women in my study.

Aim of the research

The intention of this research was to explore the feelings, perceptions and experiences of women in relation to their perineum following childbirth. It is the knowledge derived from their accounts that then leads to the emergence of ideas and theories. This is a crucial aspect of grounded theory (see chapter 2) where theory built on the information gained from the data is able to give meaning to the experience women have of their perineum following childbirth. As Strauss and Corbin (1998:25) note:

> *'A theory enables users to explain and predict events, thereby providing guides to action'.*

An investigation into this area will have relevance as a basis for appropriate information giving and planning of care during the antenatal and postnatal period. The contribution to knowledge will help address the needs of women, as identified by the women themselves, and form an integral part of women-centred care that is fundamental to the philosophy of recent government policy (Department of Health 2004). The findings may also provide a basis for future research.

CHAPTER 2
METHODOLOGY

An overview of qualitative research

Qualitative research describes a process of inquiry that seeks to explore the meaning of an individual experience or event recognising every human experience as unique (Sandelowski 1986; Morse and Field 1996). It is concerned with capturing the individual's point of view to obtain in-depth and detailed descriptions, which Denzin and Lincoln (1998:11) refer to as 'rich description'. Sinclair (2004) articulates the importance of qualitative research as a way of contributing to midwifery knowledge as it describes, maps, analyses and details the patterns of everyday experiences for women during their childbirth experience. This study captured 'rich descriptions' of women's experiences of their perineum following childbirth, which led to the development of a theory grounded in the data.

When little is known about a topic and the researcher wants to focus on the circumstance that may shape the understanding of the phenomenon being studied, then a qualitative approach is appropriate (Glaser and Strauss 1967; Strauss and Corbin 1998). It is an exploratory approach that builds a complex, holistic view from the reports of participants detailing their experiences or phenomenon. The data that is collected reflects the 'real life' or social context and when analysed, explanations are developed based on complexity, detail and context. I wanted to understand women's experiences of a particular phenomenon, of which there is little literature available. The lack of available literature influenced the decision to use a qualitative approach to explore the experiences of women.

Grounded theory is a research approach that has its roots in sociology, particularly in symbolic interactionism which aims to explain basic patterns common in social life and generate theory that is relevant to practice and research. Childbirth is more than a biological event, it occurs in a social as well as psychological context, which has an impact on the birth experience. Women gain knowledge and understanding of the birth

process as they live through it and engage with others. This perspective demonstrates how psychosocial factors are important to women experiencing pregnancy and birth. This is the methodology for this study.

Symbolic interactionism

The framework for grounded theory is embedded in symbolic interactionism, which maintains that, the behaviour of individuals and the roles they play are determined by how they interpret and give meaning to symbols (Mead 1934). Individuals make sense of the world through interaction with others and define themselves through a process of socialisation. An example in this study was that some women would talk to friends who had recently given birth wanting to know what it was like. For some women this meant however, that if their friend's birth was straightforward and they did not sustain any perineal trauma, they felt their own experience should be similar as they had 'something to live up to' (see chapter 4).

Blumer (1969) developed the process of socialisation further by stating that people do not just respond to a situation but interact with others and so play an active role in shaping their environment. Symbols can include words, gestures, clothing and objects. Within a social group, individuals have a shared understanding of what certain symbols mean to them and it is this meaning that enables the behaviour of others to be predicted. Over time the meanings may alter as individual behaviours change. When feedback is given to individuals about changes in behaviour, they begin to recognise how others see them informing their perception of 'self'. The self therefore is socially constructed in that it is influenced by expectations of others. Grounded theory explores the social processes within these interactions, drawing out what is important to the individual within their world, as they perceive it.

Rationale for using grounded theory

Grounded theory is based on the work of Glaser and Strauss (1967), which emphasises the importance of developing theory that explains and provides insight into the phenomenon that is being studied. It is a system for analysing and interpreting research data, steering the researcher through its simultaneous collection and analysis, with the purpose of making explicit the theory, which lies within the data (Glaser and Strauss 1967; Strauss and Corbin 1998; Hutchinson 2001). It is appropriate to use when there is a lack of knowledge or theory of the topic (Glaser and Strauss 1967, Hutchinson 2001). Strauss (1987) maintains that grounded theory is more structured than other forms of qualitative research such as phenomenology or ethnography, which generally seek to describe or explain the phenomenon under question but does not emphasise the development of a theory. Theory is a grouping of related concepts and proposals with 'explanatory power'. Grounded theory is the 'discovery of theory from data systematically obtained from social research' (Glaser and Strauss 1967:2).

Glaser (1992) claims that grounded theory methods are not specific to a particular discipline or type of data collection. It is an orderly and systematic method equally applicable to many fields including health, business studies or psychology. Interview transcripts, observation or documents and diaries can all be appropriately utilised. My study is related to the discipline of midwifery and used diaries and one-to-one interviews. Backman and Kyngas (1999) identify that grounded theory has been used in nursing since the 1970s. Bluff (2000) acknowledges this approach is also gaining popularity amongst midwives such as claimed by Levy (1999), Spendlove (2005) and Williams et al (2005).

The 'Straussian' and 'Glaserian' Grounded theory

Grounded theory emerged from the collaboration of two scholars, Barney Glaser and Anselm Strauss (Glaser and Strauss 1967). Since the initial development of grounded theory some consider Glaser and Strauss to have taken divergent paths in its application and evolution (Glaser 1992; Melia 1996; Melia 1997; Boychuk Duchscher and Morgan

2004). The differences are essentially related to the nature of the research question and initial coding and discovery or verification. Strauss and Corbin (1998) state that the research question is a statement about the phenomenon to be studied. Glaser (1992) argues that the question only emerges through the process of open coding, theoretical sampling and constant comparative analysis. Glaser is critical of Strauss and Corbin's approach arguing it is a process of verification and not discovery. Strauss and Corbin analyse data systematically which Glaser believes is too rigid. He argues that Strauss and Corbin, in breaking down and pulling apart all paragraphs and sentences and naming them, forces the data, that is, by making it fit into predetermined codes and categories. Glaser emphasises the need to look for patterns and relationships within the data allowing the data to tell their own story (Melia 1996).

Key to Strauss and Corbin's (1998) version of grounded theory is the emphasis placed on breaking down, comparing and categorising data using a set of procedures known as axial coding. These procedures focus on specific consequences, strategies and conditions that allow the researcher to put back the data in a new way. It is this process that is the most contentious between Glaser and Strauss (Kendall 1999). I decided to use the Straussian approach as it offered the structure I thought appropriate for someone who was fairly new to the research method (see chapter 9).

Data collection and analysis

Data were collected using diaries and interviews and the following section considers the relevant literature. Structured versus unstructured diaries will be explored as well as considering how participant diaries were used in the research and the rationale for doing so. The use of interviews to complement the data collected from diaries is also discussed in detail. The progression of data collection was unintentionally a lengthy one and that to aid clarity a timescale and overview of the process has been included at the end of the chapter.

Ross et al (1994) and Jacelon and Imperio (2005) explore the use of structured diaries with participants typically asked to record specific information in relation to some

aspect of an event or experience. Alternatively the diary may be completely unstructured where detail thoughts and feelings in relation to a particular phenomenon can be expressed. Richardson (1994) argues that formally structured documentation is not a true diary as it pushes the subject into a narrow view of their life events, and decreases spontaneity. I did not want to guide the women, which is consistent with the views of Richardson (1994) and Pittman et al (1997). Ross et al (1994), have evaluated diaries as being a reliable, user-friendly and a productive tool, but may demand more time and effort on the part of the women than, for example, a single interview. Pitman et al (1997), in preparation for their study to evaluate maternity care, also had concerns about asking women to keep a diary because of the commitment required. However, anecdotal evidence from local midwives that mothers, especially first time mothers, often kept their own diaries, was helpful in deciding this to be an appropriate means of collecting data. There was a 50 percent response rate with diaries being returned from across the range of social classes and age groups.

Initially I gathered data through individual diaries (sample appendix 2). After analysing four diaries it became apparent that greater depth and clarity could be achieved by using interviews as an additional research tool (sample appendix 3). For example where further clarification would have been helpful can be demonstrated by reference to the following extracts taken from Anne and Brenda's diary entries:

> Anne:
> *"Worried that going for a wee (passing urine) would still sting and be uncomfortable, <u>but to my surprise</u> it didn't sting at all."*
>
> Brenda:
> *"I feel <u>surprisingly well</u> today."*

Both of these entries appear to suggest that Anne and Brenda had expected something different and were surprised when it did not happen. Exploration of what it was they were expecting to happen and why was important but this was unable to be done by using diaries alone. A disadvantage of using diaries as a method of data collection is the difficulty for the researcher to explore further any questions that arise from reading the content (Zimmerman and Wieder 1977; Gibson 1995). This method of data

collection was new to me I had not appreciated the benefit of including interviews from the beginning of the process. Following further ethics approval, future women recruited were interviewed within two weeks of the diary being collected. This combined approach is referred to as the 'diary: dairy-interview method' (Zimmerman and Wieder 1977). By using interviews with subsequent women the above example informed the category 'preparing for the unknown' and is investigated in detail in chapter 4.

Other disadvantages of diaries include deciphering handwriting (Gibson 1995), which interviews after completion of the diary allow for clarification. Diaries are also time consuming to complete and instructions about how to complete the diary may be difficult to understand (Meth 2003). Both of these issues were acknowledged.

I wanted to ensure that keeping a diary was not onerous, so careful consideration was given to the style of the diary used. It was attractive and the chosen colour green, not pink or blue which is often connected to the gender of the baby. Before meeting the women I did not know whether they had a boy or girl and did not want to give them a diary that could be perceived as the wrong colour. It was A5 in size to make it easier to handle but was large enough to ensure good print size and spacing for instructions. The diary was an instrument to obtain the women's views about their perineum following birth, but also for returning to them after the content had been analysed. Therefore, crucially it was seen as being owned by the women. This was in keeping with other studies such as Podkolinski (1996) and Pittman et al (1997). Freer (1980) also believed that if accurate and comprehensive information is to be collected, then it is essential the diary is as patient centred as possible. Patients should therefore be encouraged to see the diary as their own, recording their own problems in their own words and is why Podkolinski returned them after the data was analysed.

Care was taken to ensure that the instructions in the diary were clear (appendix 4). Freer (1980) and Richardson (1994) argue it is crucial to the quality of the recorded diary information that the instructions to the women should be carefully prepared. Initially, I found it difficult to write the instructions to give a minimal amount of information whilst using a 'reader-friendly' language not loaded with professional

jargon (see chapter 9). Personal contact was made with each woman to explain the use of the diary. It was also hoped that this contact would encourage women to complete it once started. A number of factors influencing response rates are cited in the literature related to diaries. Best response rates are achieved by personal recruitment and delivery of the diary, and regular follow-up and personal collection. This ensures good initial acceptance rates, and ensures the diary is returned (Corti 1993, Gibson 1995).

The women kept the diary for 10 days following the birth of their baby, which matched the minimum number of days a midwife must attend women in the postnatal period (Nursing and Midwifery Council 2004a). This time frame met the parameters of my study, to provide a basis for appropriate information giving and planning of care for women in the postnatal period. Although women might experience difficulties beyond 10 days it was an appropriate cut off point. Richardson (1994) identifies that whilst health diaries can be maintained from one to two weeks to over one year, and initial completion is high amongst participants, there is a consistent drop in the reporting of incidents with time. The 10 days in this study captured sufficiently the behaviour or events of interest without jeopardising successful completion by imposing an overly burdensome task. All women recruited to the study completed their diary.

Diaries, according to Gibson (1995), provide the researcher with an unobtrusive way of tapping into intimate areas of people's lives that may otherwise be closed. This was evident in the diaries written by the women in this study, where examples of intimate experiences such as sex and femininity were included. This is noted in Amanda's diary where having sexual intercourse was something that concerned her and is considered further in chapter 8:

> *"Still not sure about sex before my six week check though."*

Unstructured diaries were used, except for a brief introduction at the beginning reminding women how to use it (appendix 4). This approach was used to enable women to record in their own words, descriptions and perceptions of events and feelings over time. Richardson (1994) verifies that this is consistent with Allport's original classification of diaries, which includes an intimate journal that gives account

of thoughts and feelings. The diary provided an opportunity for women to write about their thoughts and feelings as near to an event as possible, so they did not have to rely on memory to recall past experiences (Mateo 1991). Rakowski et al (1988) argue that participants may recall past experiences as being more serious or not so serious depending on what long-term effects remain, rather than based on the discomfort or disruption of routine that occurred at the time of the event. This was relevant to my study enabling exploration of events that were experienced by the women at the time rather than recalling an event that may have lost significance several months later.

The women were encouraged to record whatever was important to them, even if they felt it might not be what was wanted. When analysing the diaries, it was clear the women were not inhibited in their writing, as shown by Sarah's entry describing events leading up to the birth of James. The progress of Sarah's labour was taking longer than normally expected, due to the position that her baby's head was lying in the birth canal. This made it more difficult for the natural progress of labour to take place:

> *"Baby James was born at 9.42pm last night and I had a forceps delivery, which involved an episiotomy and obviously stitches. I feel I suffered an ordeal I would very much like to forget...my waters broke at 5am yesterday morning and within ½ hr I was having contractions every 3 minutes. Made our way to the hospital at about 9am and used TENS (transcutaneous electrical nerve stimulation) machine until I got in the pool at around 1pm when I started using gas and air. I spent approximately 8 hours labouring in the water. However James's head was at an awkward angle and as such, despite me pushing really well – it really was taking such a long time and I was absolutely shattered. They called the Registrar who performed a forceps delivery. Despite having injected local anaesthetic to the area – I was <u>not numb</u> and felt <u>everything</u>* (Sarah's emphasis) *– my husband had to pin me down onto the bed using some force. I was told to push on the next contraction once the forceps were inserted but I really was in so much pain from her having inserted them I couldn't tell if I was having a contraction or not!!! So I just pushed anyway and his head was born on the 2nd pull/push. I actually felt her cut me and then stitch me."*

This and similar entries in other diaries, has powerfully informed part of the discussion chapter where I explore and consider how perineal issues cannot be separated from the birth story.

The diary: diary-interview offered a number of advantages. Clarity was sought from entries in the diary (Zimmerman and Wieder 1977) and expanded into themes during the interview. To illustrate this Fran wrote in her diary soon after the birth of her daughter, Abby:

> *"the bath felt nice to be clean."*

Reference to bathing and being clean occurred several times in the diary. When explored further in the interview Fran explained that bathing so early after giving birth had not happened following the birth of her previous two children. This enabled Fran to talk about her experience of feeling considerably more normal compared to when she went home previously. Being clean and feeling normal were explored in further interviews as well literature related to the cultural significance of being clean. Scott and Henley (1996a) for example identify that washing extends beyond being just a physical task but is a means of ensuring social acceptability and the person being comfortable with the way they present themselves. This led to the coding of 'wanting to be myself again' (see chapter 8).

The interview supplemented data collected from the diary. The diary acted as an 'aide memoir' for events that were difficult to recall accurately or were forgotten. It was recognised in this study that women could be pre-occupied much of the time with caring for their newborn baby and that recall could be coloured by the new role and responsibilities women had. Corti (1993) argues the diary: diary-interview is the most reliable method of obtaining information and is the closest to direct observation. The interview provided a rich source of information related to the women's behaviour and experiences on a daily basis. The diary: diary-interview also provided an opportunity for discussing more intimate details contained within the diary that might have remained 'silent' if the interview alone was used.

Initially an unstructured approach to the interview was adopted, enabling flexibility and encouraging the interests and thoughts of the women to be expressed and heard. The

interview started with a general question, 'Tell me about…' An 'aide memoir' was available during the interview to prompt questions from the diary if they were not spontaneously covered. Wimpenny and Gass (2000) indicate that in grounded theory the ongoing analysis will influence the questions asked, resulting in the direction and questioning in the interviews becoming driven by the emerging theory. This indeed did bring a sharper focus to subsequent interviews, which resulted in their format becoming more semi-structured in nature. For instance, as the analysis progressed there was an interest to understand further the idea of 'returning to normal', and so some of the questions were related to this if it was not raised spontaneously by the women.

> SW:
> *"What sorts of things were normal to you? Can you explain what normal was?"*
> Hannah:
> *"Yeah (um), well I think I mean (um, laughs), well I put some washing on er making some dinner…"*

Each interview took place within two weeks of collecting the diary. It was hoped that this limited interval would enable women to recall, (with prompting from the diary if necessary), events that would be useful to explore in more depth. Early transcribing of the interview allowed for preliminary analyses of the data, identifying initial codes. These then formed the basis of the meeting with subsequent women, asking them to expand on issues, further enriching the data.

Interview dates were agreed with the women when collecting their diary. All agreed for the interview to take place in their home, at a time that was convenient to them. Before arriving for the interview the women would be telephoned to check that the time was still suitable, recognising that the needs of the baby may require adjustments to the initial time agreed. When I met with Janet the timing was rearranged for later in the day. She had been up for most of the night with Thomas, and was going to bed for some sleep.

Interviewing in the women's homes meant there might be unavoidable distractions as the need to provide care for the baby was a priority. I believed it was important that if the women wished, they should have their baby with them to reduce any anxiety that

may arise in trying to find someone else to baby-sit. My experience during the interviews was, that it was not the baby that caused the distraction, but the telephone. On several occasions the tape machine was turned off while a telephone call was answered.

In all but one instance the women had their baby with them, the exception was where the father provided care away from the interview area at the woman's request. At the commencement of the interview it was emphasised to the women to feel free to stop at anytime if they needed to tend to their baby. On several occasions women would be breastfeeding at the start of the interview, or would be cuddling and settling the baby ready to put them down to sleep. This was an important approach in helping to facilitate an environment where women felt comfortable to talk.

All interviews were audio taped and transcribed verbatim soon after the meeting. The transcribing was done by the researcher, which was helpful in stimulating the analysis of data. Data collection took place between September 1998 and May 2004.

Coding and categorising

Constant comparative method of analysing and theoretical sampling underpin the process of data collection (Glaser and Strauss 1967; Strauss and Corbin 1998) and serve to facilitate the generation of theoretical ideas that are rich in both conceptual and theoretical terms.

The constant comparative method of analysing involves simultaneously collecting, coding and analysing the data in order to decide what data needs to be collected next. Data collection and analysis are therefore linked from the beginning of the research and interact simultaneously. According to Glaser and Strauss (1967), this constant comparative method focuses on generating and plausibly suggesting numerous categories, properties and hypotheses from within the data.

Analysing the data involved examining words, phrases, lines and paragraphs of the diaries and transcripts to discover and name concepts expressed by the women in the study. Early in the research process codes were identified. Strauss and Corbin (1998) refer to these as substantive codes, so called because they come from the substance of the data. Codes were initially labelled with words used by the women (in vivo) for example, to ensure their meanings were closely captured. Words also identified by the researcher were used.

Each code was compared to all others for similarities, differences and general patterns (Strauss and Corbin 1998). Similar codes were then linked together to form categories. This forming of categories moves the data to a more abstract level generating further categories (appendix 5) to explore in preparation for the next interview. Thus, questions were generated from the data and one event was compared with another. Each diary and interview was compared and as new ideas emerged further comparisons were made, this being an ongoing process rather than a one off event. Therefore the data were modified as directed by the advancing theory (Streubert and Carpenter 2001; Holloway and Wheeler 2002). For example, the instructions in the diary were updated after 6 women had completed them (appendix 6). This was to reflect the emergence of the category that some experiences the women were describing had not been expected. Instructions in subsequent diaries asked the women to comment if the experiences they were writing about had been expected. The category, 'preparing for the unknown' (see chapter 4) resulted from further abstraction of the data.

Formulating a definition based on the properties inherent in categories was the next step. Axial coding (Strauss and Corbin 1998) enables data broken down in open codes to be connected and reassembled again into categories. An example of the descriptions related to bathing or having a shower and how connections were made in preparation to reassemble into the sub-categories, 'coping with the body' and 'achieving independence' are given in appendix 7.

Literature search strategy

After the introductory literature review (see chapter 1), the next formal stage of considering the literature was guided by the emerging categories (Glaser and Strauss 1967; Strauss and Corbin 1998). At this point the literature became another source of data that was incorporated into the main body of the study. Reference to the literature continued throughout the research study, which means ultimately the literature is extensively reviewed. In the context of this research, further literature was not accessed until the first four diaries were analysed.

Following the analysis of the first four diaries a number of themes were emerging. For example, women having their second or subsequent baby identified that previous experiences of perineal pain appeared to be important in preparing them for the impending birth. This was different from those women who had not experienced perineal pain before. The apparent difference in preparation led to exploring the literature related to antenatal preparation classes and asking women in further interviews if attending preparation classes were helpful in preparing them for any perineal pain and discomfort that may be experienced. The use of the literature at this point enabled the researcher to compare and contrast findings with those of other studies. This led to the development of the category, 'preparing for the unknown' (see chapter 4).

Searching the literature involved two methods, the incremental approach and broad-brush approach (Burnard 1993). The incremental approach tracks back one or two key papers that are read and then key references that the author cites are again traced and so the process continues. In this way a systematic search of the literature is undertaken exploring one aspect at a time. An illustration of using this approach is the article by Small et al (2000), who explored midwife-led debriefing to reduce maternal depression at operative childbirth. A number of other papers related to 'debriefing' were traced from the reference list.

The broad-brush approach to searching the literature involves the researcher amassing as many reference about a particular topic as possible and then filtering through the

references and choosing the ones that are particularly pertinent to the study. Data-bases that were accessed when searching the literature included the British Nursing Index, CINHAL, MEDLINE, Cochrane and MIDIRS. The information had to be written in, or translated into English. Key words used for example, when searching the literature related to perineal trauma included 'perine* tear', 'perine* trauma', 'genital tract trauma', 'perine* repair' and 'birth trauma'. Further references were retrieved from journal articles and books and through personal contact with experts in the field.

The literature can also be used to validate the researcher's categories. Available evidence may support the researcher's findings but may also identify disagreement. Where the literature challenges the researcher's findings the reasons for this are explored. An example of where the findings in this study challenge the literature relate to the work of Holloway and Bluff (1994) where it is argued that women believe the midwife 'knows best' what care to give during labour. This view is not upheld in my study as demonstrated by Amanda for instance, who questions the ability of the midwife (see chapter 7).

It is acknowledged that ultimately the researcher has to choose which literature is relevant to the study under question and follow-up, and which to reject, making a decision about what is and what is not appropriate to the study.

Sampling strategy

Morse (1991) advises that sampling be both appropriate and adequate. That means that the method of sampling must fit the aim of the study as well as help the understanding of the research problem. A sampling strategy is adequate if it generates sufficient and relevant information and satisfactory quality data (Holloway and Wheeler 2002). A purposeful sample was initially used. That is women were 'purposefully' selected to provide information about the area under study (Patton 2002). Individuals are selected based on the researcher's first-hand experience of a culture, social interaction, or phenomenon of interest (Streubert and Carpenter 1999). Porter (1996) identifies that the initial decision regarding sampling is the only one that can be pre-planned, since the

selection of all other data sources is controlled by the emerging theory. As important issues emerge, theoretical sampling takes priority (Glaser and Strauss 1967; Coyne 1997). This type of sampling facilitates the development of theory by enabling new participants to be sought in response to analysis of the data. This provides the greatest opportunity to gather the most relevant data about the phenomenon under investigation (Strauss and Corbin 1998).

The aim of this research (see page 19) was to explore the feelings, perceptions and experiences of women in relation to their perineum following childbirth. The researcher was aware that individuals needed to be selected with the likelihood they were to experience a vaginal birth, and not intending to birth their baby by caesarean section. Initially, women were selected on the basis that they were planning to have a vaginal birth, regardless of them experiencing a straightforward pregnancy or one where they had complex needs. A local, midwife-led antenatal clinic in the South of England was used as a base for the recruitment, which began following ethics approval in 1998. The characteristics of the women, relevant to the phenomenon being studied are given in appendix 8.

After recruiting four women to the study and analysing their diary entries, several issues began to emerge. Women who already had children described their experience as better than before. It was also noted that although all the women had been classified as having 'minimal' perineal trauma by the record of the birth written by midwives, the pain the women experienced was variable. These emerging issues led to sampling women who were having their first baby, and women who sustained a greater degree of trauma to see if their experiences differed. A personal field note entry reflects this decision:

> *"It is evident that the first four diaries are from women who have only sustained grazes and no stitches. Although this is 'minimal' trauma they write about varying degrees of pain. Those who have had babies before refer to the pain being better than before. I need to sample some women who have had a 'greater degree' of trauma to see if their experience is different. This is difficult to sample for until after the birth because I don't know who will tear / need at episiotomy until after the birth. This will need to be handled sensitively because I don't want to say to the women, 'sorry, but your tear wasn't big enough!'"* **July 1999**

The next two women recruited to the study each sustained 2^0 perineal tears. The analysis of their diaries and interviews highlighted that the perineal pain and discomfort they each experienced differed in severity despite their perineal trauma being classified as similar. This led to the sub-category 'the experience and assessment of perineal pain', (see chapter 5). Georgina was the next woman to be recruited. She already had three children and her experience of giving birth to a subsequent baby had similarities with the experiences of Anne, Clare and Debbie which informed the sub-category, 'preparing second time round', (see chapter 4).

The first seven women recruited to the study all had a spontaneous vaginal birth. Issues of control over the birth process and feeling guilty about not being able to prevent the perineal trauma sustained began to emerge. In view of this the next three women recruited, Janet, Hannah and Sarah all had an assisted vaginal birth. Their views and experiences added a different dimension to the phenomenon being studied and informed the categories 'getting back to normal' and 'recovery of self'. In total, 11 women participated in my study. Justification for this number is explored further on page 36 where sample size is discussed in more detail.

Lincoln and Guba (1985) and Leininger (1994) suggest sampling continues until saturation has been achieved, that is, until no new information is generated, there is repetition of information and previously collected data are confirmed. Saturation therefore occurs when further theoretical sampling does not uncover new ideas when additional participants are included that are important for the developing theory. Saturation extends beyond concepts mentioned frequently and described similarly by many people, or when the same ideas arise repeatedly, but are obtained when the theory fully explains variation in the data (Strauss and Corbin 1998). Morse (1989) argues that saturation is complete by the quality of the theory that has been developed for that specific culture, warning that saturation may not be absolute as it depends on timing, the group of participants and the context in which the study is taking place. She believes that if another group of individuals were observed or interviewed at another time, new data may be revealed. In my study the collection of data stopped when the same ideas were repeated and no new information was being heard.

The inclusion of negative cases or the views of participants that differ from others provide a balanced perspective (Morse and Field 1996). This was evident from the category 'getting back to normal', where it is identified that part of the process of regaining independence was the move from being dependent on family and friends for help to being able to do things more independently. However, Hannah found her relatives most unhelpful and ended up taking on the role of hostess when they came to visit rather than her family doing things for her.

Sample size

Sample size is determined by theoretical saturation of categories so tends to be small but the data are full and detailed. Qualitative research allows for greater flexibility in sample size than does quantitative methods. For example, in quantitative research particular rules are observed to ensure representativeness and generalisability. These include the random selection of subjects, random assignment to experimental and control groups and predetermined sample sizes to ensure the proper use of statistical tests of inference (Sandelowski 1986). This is shown clearly in the study by McCandlish et al (1998) where the primary hypothesis to be tested was that a policy in which the midwife keeps her 'hand poised' at the time of delivery reduces the occurrence of perineal pain in the previous 24 hours reported by the mother ten days after the birth when compared with a policy of 'hands off'. There sample size was based on an estimate of 23 percent of women reporting perineal pain at 10 days after birth meaning 8,500 women would need to be randomised to detect a reduction in reported pain to 20.5 percent. The randomisation of women took place at the end of the second stage of labour when the midwife considered a vaginal birth was imminent. Women were either allocated to the 'hands on' or the 'hands poised' group.

In contrast Patton (2002) argues that no guidelines exist for sample size in qualitative research, which may be large or small. It is generally accepted that qualitative sampling can consist of small sampling units studied in depth. Qualitative research does not produce generalisable findings but the sample groups are typically representative of a class or group of the phenomenon being studied. Spendlove (2005)

included seven midwives in her study to gain an understanding of the process by which midwives make professional decisions regarding management of perineal trauma following spontaneous childbirth. Midwives were recruited from a multi-sited NHS Trust in middle England with data being collected through tape-recorded, semi-structured interviews. Data collection and analysis were led by the constant comparative method. The decision making process of the midwives with regard to the management of perineal trauma following spontaneous childbirth was found to be a two-stage process. The two stages were identified and named as the 'assessing phase' and the 'contemplating phase' with the outcomes of these two stages being a clinical decision. Implications for practice included the need for midwives to reflect on their practice in this area and be comfortable with their evidence base and skill. Particular strengths of this study included midwives having recent intrapartum care experience enabling easier recall of the knowledge and skills required to assess perineal trauma and the subsequent necessary action to suture the perineum or to leave to heal naturally. Theoretical saturation is identified as having been achieved after seven interviews, despite 12 midwives being recruited to the study. Spendlove was clear from the outset of her study that it was neither expected nor intended to produce findings generalisable to midwifery, but rather to identify issues that may provide focus for future research and to raise professional awareness of midwifery decision-making regarding management of perineal trauma. Spendlove concludes that the study contributes to the published research on this subject

In my study a small group of fairly homogeneous participants were accessed (appendix 8). All women were of British, Caucasian origin living in one particular area in England, aged between 20 years and 42 years, and except for one woman, living in detached or semi-detached accommodation. All women appeared to be in a supportive relationship. Six women gave birth to their first baby; two women to their second baby and one each to their third and fourth baby respectively. Other groups of women were not purposefully excluded from the study, they just did not happen to be around when the sampling was undertaken. No claims are made as to the wider generalisability of the findings, but it is nevertheless anticipated that, related to a wider context, at least some of the category description may 'ring true' to midwives and others. Chapter 9 explores further issues related to limitations of the study.

Ethical considerations

Ethical principles are important in relation to protecting the participant from harm and risk and are necessary to consider for all types of research, not just grounded theory. Research is considered to be ethical if it satisfies the demands of beneficence (always do good), justice and respect for those involved (Beauchamp and Childress 2001). Ethics approval for the research was sought through the Local NHS Research Ethics Committee.

Gaining approval

The completed 'request for ethics approval' form was approved at the first submission. One condition of gaining ethics approval was consent from the Clinical Directorate who in this instance was a Consultant Obstetrician. I also needed to write to all the Obstetricians within the Trust where I was hoping to recruit the women from. Although not a pre-requisite of the ethics approval, I also sought agreement from the Head of Midwifery, who was a 'gatekeeper' to the women whom I wished to access. She gave me the support to speak to midwives within the Trust who were willing to initially talk to the women about the research, so helping in the recruitment. This support proved invaluable.

Polit and Beck (2004) state the rights of any individual involved in a research study include confidentiality, anonymity, voluntary participation, informed consent and to do no harm. Each of these aspects has been considered.

Confidentiality and anonymity

Confidentiality was explained at the initial contact and several steps were taken to ensure this. Anonymity was maintained as far as ethics approval allowed and was explained to the women that a condition of ethics approval was that the General Practitioner and / or Consultant Obstetrician were to be informed of their participation

(appendix 9). This I did once I had received the completed consent form. All diaries, audio and transcribing materials were kept secure with restricted access. Each woman participating was given a pseudonym in the transcript, along with a name for her baby. If the partner contributed or was named in either the diary or interview, he also was given a different name. The use of names reflects the importance of giving each woman an identity and acknowledging their contribution (Donnell Connors 1988). No identifiable information was kept on computer and the paper work that linked their name with the pseudonym used in this research was kept locked away with only myself having access.

At the initial contact it was explained to the women that if they agreed to take part, the midwife who was present at the birth would need to make contact with me, giving brief details about the birth. When informed of the birth I met the women within 24 hours and gave them the diary. This was another way of confirming they still wished to take part. This process altered slightly as the study progressed due to a change in circumstances of the researcher. Part way through the study I changed jobs, which meant not being able to meet with the women within 24 hours of the birth of their baby. A new process was developed which meant when the consent forms from the women were received, their diary was sent out by return of post. When the midwives informed me the women had given birth I rang them on their return home and reminded them about the diary. This change is circumstance is discussed further in chapter 9. Prior to commencing the interviews, it was further clarified with the women that they agreed to the interview being tape-recorded. It was also confirmed they could stop the interview at any time they wished.

Not to be harmed

As a registered midwife I had a duty of care to the women and needed to comply with the Nursing and Midwifery Council's *Code of professional conduct: standards for conduct, performance and ethics* (2004b) and *Midwives rules and standards* (2004a). If the women talked about the care they received as being inadequate or inappropriate, they were encouraged to speak to their midwife or health visitor who would still be

visiting them. If they felt unable to do this, then they were encouraged to talk to a local Supervisor of Midwives, who had agreed to this commitment.

Voluntary participation and informed consent

Seeking consent is a process that incorporates the giving of information, discussion and decision-making. All medical and research ethics committees maintain that informed consent must be obtained from patients or participants. Consent was obtained from the women after 34 weeks of pregnancy. This meant there was enough time to explain the study to the women, before the onset of labour, and for the women to take written information home and discuss with their partner, and midwife if they wished, before making a decision. This practice is commended by Robinson (1997) following concerns that women were being asked to consent to taking part in research trials related to interventions in labour at the time they were actually in labour. Robinson identifies that women in labour found it particularly difficult to refuse unwanted treatment.

Giving women in my study time to read the information they received meant they were able to ask for further clarification if they required it, as my contact details were given to each woman I spoke with. This time span also meant that not too much time had elapsed from the initial contact, before the baby would be born (a maximum of eight weeks), hopefully reducing the likelihood of the women forgetting.

Talking to women about the study took place in a separate room, away from the clinic environment, to ensure privacy. They were shown a specimen diary so they knew what it looked like, and it was hoped that this would alleviate any anxieties about filling in a 'big book'. In giving women time to consider their decision, before they went away, they were handed a written summary of the research aim. When further ethics approval was granted to include interviews, the information sheet was updated to reflect this (appendix 10). The women also took away two consent forms (appendix 11), one to be returned completed if they wished to take part and the other to keep for their own

records. A stamped, self-addressed envelope was included.

I was aware when talking to the women about the focus of the research that obtaining informed consent in qualitative research has inherent problems (Holloway 1997), because when the research starts there are not any specific objectives. I was not able to inform the women of the exact path the research would take - although telling them the aim and intentions – and I did make them aware that the research may not benefit them directly but would hopefully influence future postnatal care by highlighting the needs of women during this time

Rigour of qualitative research

Rigour is the means by which integrity and competence of the research process is demonstrated, and without it the research may be worthless (Tobin and Begley 2004). The integrity of research has been judged in the past by using terminology such as validity and reliability (Guba and Lincoln 2005). Tobin and Begley argue validity and reliability is a language belonging to the quantitative research paradigm, rather than being a language of research per se. The use of the terms validity and reliability in qualitative research was necessary in the past to 'prove' that an 'unbiased' approach had been used in order to gain credibility from the scientific community (Lincoln and Guba 1985; Leininger 1994)

In their seminal work in the 1980s, Guba and Lincoln substituted validity and reliability with the parallel concept of 'trustworthiness', containing four aspects: credibility, transferability, dependability and confirmability (Morse et al 2002).

Credibility is concerned with the participant's ability to recognise the truth of the researcher's findings and can be identified by providing participants with the opportunity to review the researcher's interpretation of the data (Koch 1994; Cutcliffe and McKenna 1999). However Morse (1998) argues that qualitative research is more than a description of the data and questions whether people would recognise their personal contribution. This is because they are unlikely to have learned these

intellectual skills to understand the rigorous process of analysis, interpretation, abstraction and synthesis that has taken place. In my study I used the analysis of the diary to explore in the interviews my understanding and interpretation of what the women had written. When starting off the interview I explained this aspect to the women so they were at liberty to correct me if I had misinterpreted anything. I believe the level of abstraction that Morse refers to had not taken place in the diary by the time I went to interview the women, this came later in the research process. Therefore, the women would have been able to recognise their contribution at this stage of the process.

Sandelowski (1986) and Patton (2002) say that credibility is particularly dependent on the credibility of the researcher. This is because in qualitative studies the researcher is the research tool and therefore becomes part of the research study. In order to enhance credibility researchers should make explicit what they bring in terms of qualifications, experience and perspectives. Mason (1996) also identifies the need for self-scrutiny, or active reflexivity. The researcher constantly evaluates their actions and their role in the research process subjecting these to the same critical scrutiny as the rest of their data (Kingdon 2005). Reflexivity is a concept central to qualitative research. Chiovitti and Piran (2003) express that using a personal journal as a method where the researcher articulates their personal views and insights about the phenomenon, enhances credibility in grounded theory. It is a process where the researcher should engage in continuous self-critique and self-appraisal and explain how their experience has or has not influenced the stages of the research process (Koch and Harrington 1998; Hand 2003). In keeping with Hutchinson's (2001) and Koch's (1994) recommendations I kept a reflective diary to maintain my awareness of how I may have influenced the women or indeed how the women may have influenced me, and the effect this may have had on the study. Relevant extracts from the diary are shown in the chapters.

Carolan (2003) places a note of caution in the use of reflexivity arguing that the separation of the nurse from the researcher is a key issue for nurse researchers. This is probably difficult to achieve, as it may be that the nurse as the researcher that promotes patients to consent to participate in the qualitative study in the first place. This raises an ethical dilemma where the nurse's identity is used to recruit participants and then

shed once the study begins. This is also an issue for my midwifery research as I made it clear in the information given to women that I was a midwife, when I discussed the study with them, prior to them agreeing to take part. This may have influenced their decision to take part, and perhaps enhanced their wish to talk freely about intimate areas of their body, as these are common issues addressed by midwives on an everyday basis.

Transferability is where the readers recognise the truth of the research in relation to the social contexts known to them. In this study transferability would relate to the reader understanding what the women were saying in relation to their birth and early postnatal experience as it affected their perineum. This helps to determine whether the findings can be applied in other contexts or settings with other groups. Seale (1999) refers to this when the findings of a qualitative study are applicable in situations other than the one studied. If in-depth and detailed description is included in accounts of qualitative research then readers can form their own judgements and compare them to the conclusions of the researcher. Morse and Field (1996) point out that identical results would not be expected because qualitative research emphasises the uniqueness of the human situation, so that variation in experience is expected, rather than identical repetition.

If a study is judged to be dependable it must be consistent and accurate. One of the ways in which the research may be shown to be dependable is by providing an audit trail of the process, which means a detailed description of the path of the research (Streubert and Carpenter (1999). Readers could then carry out future research following the path of the researcher. I have given the audit trail of this research

Confirmability means that the findings are the result of the research and not the outcome of the biases and subjectivity of the researcher (Holloway 1997). The audit trail used to determine dependability can also be used to aid the reader that the findings reflect the result of the research.

Tobin and Begley (2004) recommend that the integrity of the research must be reflected throughout the study and not confined to the methodology chapter. Examples in this

study, demonstrating rigour throughout include the rationale for using a grounded theory approach, reflection concerning my relationship as the researcher with the women in the study and the process of identifying new insights from the presentation of the data.

An overview of the study and its time scales

This study spanned from 1998 to 2006. This was not, as will be described, the original intention, but was influenced by unforeseen events. To aid clarity over this time span an outline giving the timings of significant points in the duration of the research can be found in table 2.0 (page 46). An explanation of the overall structure is given below.

Following ethics approval in May 1998, the first group of women were recruited to the study using the process outlined on page 34. After initial analysis of the first four diaries it became apparent that data collection would be enhanced by being able to explore in more depth what women meant by some of the comments made in their diaries. Further ethics approval was sought, in respect of this, in June 1999 and was granted in September 1999. During the same month my daughter was born, ut due to unforeseen circumstances it became necessary to suspend my studies, which was recommenced in April 2001. The Local Ethics Committee was aware of the suspension and granted approval to recommence from September 2001.

Chapter 9 identifies a change in employment from October 2001, which required significant travelling on a daily basis. The extra demands related to the new job required a new process for recruiting women to be developed. Previously, the diaries were personally handed to the women within six hours of giving birth. This was no longer possible, so once the consent forms were received, their diary was sent out by return of post. When the women had given birth, on their return home a phone call reminding them about completing the diary was made. Three further women were recruited to the study. However, progress was slow due to the heavy workload of midwives and this extra demand of approaching women to potentially take part in the study, was not a priority for them. Therefore, by autumn 2003 further adjustments

were made to the recruiting process, which are described in more detail on page 177. In essence, two midwives were located who had an in-depth understanding of research, which included an appreciation of the difficulties of recruiting participants to research studies.

The constant comparative method of analysis continued to guide the theoretical sampling resulting in three more women being recruited through until spring 2004. Writing up the findings of the study was a continuous process until submission in summer 2006.

Summary

This chapter outlines the methodological framework used within the study. In line with the grounded theory approach, theoretical sampling and constant comparative analysis have been central to this study. Ethical issues related to this research have been addressed and steps taken to ensure rigour and trustworthiness.

Data from 11 diaries was collected and seven unstructured interviews conducted. The subsequent chapters explore the findings from the data. Five major categories were identified:

- Preparing for the unknown
- Experiencing the unexpected
- Adjusting to reality
- Getting back to normal
- Recovery of self

These categories have been used as the framework to present the data in the forthcoming chapters.

Ethics approval granted	28 May 1998
Diary collection: Ann Brenda Clare Debbie	 Autumn 1998 Autumn 1998 Autumn 1998 Spring 1999
Further ethics approval sought	4 June 1999
Further ethics approval granted	30 September 1999
Birth of my daughter	21 September 1999
Suspension of PhD studies due to the ill-health of my daughter following her birth	November 1999
Return to PhD studies	April 2001
Ethics Committee informed of my intention to recommence PhD studies	31 July 2001
Ethics approval reinstated	27 September 2001
Recommenced process of recruiting women	October 2001
Moved to new job	October 2001
Set up different system for recruiting women	January 2002
Diary collection and interview: Amanda Fran Georgina	 Summer 2002 Autumn 2002 Autumn 2002
Further changes to recruitment process	Autumn 2003
Diary collection and interview Hannah Sarah Janet Ruth	 Winter 2004 Spring 2004 Spring 2004 Spring 2004
Submission of thesis to the University Research Committee	Summer 2006

Table 2.0 - Overall structure of the study including timescales

CHAPTER 3
STRIVING FOR NORMALITY

Introduction

In accordance with qualitative research as described in chapter 2, the findings of this study have been integrated with the discussion that takes place throughout the following chapters. The literature challenges and confirms my own data. Findings revealed that following childbirth women expressed a strong desire to get back to normal reflecting the core category 'striving for normality'. This chapter explores the meaning of normality in the context of my research which investigated the significance of the perineum following childbirth, what it means to women and the impact it has on midwives' practice in relation to the care they offer women, especially during the postnatal period.

Normality for women, in the context of the core category 'striving for normality', meant doing normal things and feeling like their normal selves. Much of what the women described doing during the early postnatal period was related to achieving that goal. The initial impact of childbirth on the perineum and surrounding area meant that in the first few days women largely concentrated on managing the effects of this. The impact however, went beyond the immediacy of coping with bodily functions extending into other daily activities in terms of managing and completing them.

The data demonstrates and clarifies three distinct aspects. Firstly, coping with the unexpected changes to the perineum as a consequence of childbirth meant that the women frequently made adjustments to how they carried out essential activities such as walking, sitting and passing urine, in order to carry on as normal (see chapter 6). Georgina gives an example of this explaining why she needs to move slowly when getting on and off the bed:

> *"...the area (perineum) is swollen and feels delicate so I walk slowly and get on and off the bed gently so as not to stretch it."*

In relation to the second aspect the data demonstrated there were activities that were not essential but which women felt necessary to undertake, often with a sense of achievement

when completed. Brenda, towards the end of her diary, describes that by mid-morning she was well enough to be able to complete the housework and even be ready herself:

> *"Feel very well today, all household chores completed by 10 o'clock am and I'm even ready myself."*

The third distinction demonstrated by the data identified women's feelings related to their body as a result of the perineal trauma they sustained, and what helped them to feel like their 'normal selves' again. Hannah, five days after the birth of David, explains in her diary that by wearing her own clothes she is beginning to feel she is getting back to normal:

> *"Feeling practically back to normal today. Was up and about as normal this morning. Am fully clothed and back to normal behaviour."*

This is in contrast to an earlier diary entry where Hannah was having difficulty in sitting and caring for David and also remarks she was still in her night wear:

> *"I am having no trouble with caring for David. Still bleeding a lot. Only struggle is sitting still for too long and stiffening up. However have sat around in nightie all day."*

The impact of being dressed in day clothes and wearing familiar garments led to the category, 'recovery of self' (see chapter 8).

The three distinct aspects described above are the basis of the five categories that emerged from the data (appendix 12):

- Preparing for the unknown
- Experiencing the unexpected
- Adjusting to the reality
- Getting back to normal
- Recovery of self

These categories have resonance with Maslow's hierarchy of needs (Eysenck 1998), especially the lower order needs, and is discussed in more detail in chapter 8.

Striving for normality

Analysis of the data revealed that following childbirth women were immediately aware of their perineum and surrounding area, due to the stretching, swelling, bruising and sometimes tearing of muscle and tissue that occurred. The following vignettes extracted from transcription of interviews with the women, illustrate the experience of their perineum and surrounding muscle being stretched, bruised or torn. Janet reveals that she thinks her pelvic floor muscles will never be the same again:

> *"I tried to do pelvic floor exercises but I couldn't feel the muscles I was supposed to pull in. I did think maybe I wont mend back to normal but I am going to persevere."*

Hannah in one of her early diary entries highlights how painful her perineum feels:

> *"Also feel like my whole bum is sore and inflamed. Eventually I managed to get up but wish I hadn't. Can't sit down flat on anything including the bed as it is very painful."*

A consequence of these changes was that women needed to make adjustments to their daily living activities, which for some were unexpected as described by the following experience from Sarah:

> *"...if I wasn't laying down I would be sat to one side, to one side, certainly on my left bum cheek, I've spent a lot of time sat there, or with my legs up on the sofa like that (demonstrating) off to one side. But really laying down was the one thing, although it didn't stop the pain, it did relieve the pressure a bit,"*

Sitting like this was unnatural for Sarah and she knew it was uncomfortable for her back, which is explained by the following extract:

> *"I was actually worried I was going to have to see a chiropractor afterwards because I have really been sitting off set and I don't expect it is doing my back any good at all."*

These events impacted on how women experienced their perineum and can be likened to the findings from the work of Madjar (1997). Madjar's doctoral study about patients' experiences of pain, particularly clinically inflicted pain, refers to the 'habitual body'. Madjar describes the 'habitual body' as the familiar body that is lived in, known to be

reliable; sleeps at night and wakes in the morning, moves effortlessly and is taken for granted. The impact of childbirth on the perineum meant that the attributes of this familiar body had noticeably changed in the postnatal period for the women recruited to this study. The women describe incidents where their body is no longer seen as reliable for example, having difficulty in passing urine and when opening their bowels.

Janet:

"I was definitely (scared about going to the toilet). That's it because then you, I got to thinking I can't, I can't push (laughing), so I am going to have to sit here for hours until nature takes its course. It was quite painful at that point."

Further descriptions and exploration of the literature in relation to how women modified certain activities of daily living is revealed in chapter 6 in the category, 'adjusting to the reality'. It is the loss of the familiar body that the women in this study strived to regain. Women felt they were making progress and getting back to normal when the changes and resulting adjustments to lifestyle were getting less or no longer required. The two following examples, firstly from Amanda and then Debbie, illustrate the point:

"Generally I'm really happy that everything is healing so much quicker than I expected and I just get on with things without a real thought – I couldn't have imagined that 10 days ago."

"I now feel that almost everything has returned to almost normal. The small amount of bruising I had around my perineum and vagina has healed and I am able to forget about stretching that had happened in my birth canal".

As these examples demonstrate, returning to normal is a significant factor to the women during the postnatal period. The concept of normality however is complex not least when applied to the events of childbirth. There is an insistence on birth being a normal experience (Oakley 1984) and this could be contradictory and confusing for these women. Birth may be 'normal' in that it is, like death, inherent to all life but it is not without its consequences: some rarely noticed, some acute and painful and others which may result in permanent damage, chronic illness or even death. Returning to normal as described by the women in this study does imply that childbirth is an event that requires time to heal and recover from, before feeling normal again. Although, it is possible for a 'normal' event to impact in a manner that needs recovery time, nevertheless there is an ambiguity here that has the potential to influence women's

experiences. If birth is emphasised as a 'normal' and 'natural' process the experience of pain and discomfort may come to be viewed as 'abnormal', or an illness, which could in turn make the process of recovery more difficult. 'Normal' may imply that painful, difficult or distressing aspects of childbirth are 'abnormal' and could lead women to feeling inadequate because their childbirth experience had not been 'normal'. This raises the question about whose definition of 'normality' is utilised when providing care and whether midwives and women share the same reference point: a dilemma that led me to reflect during the study about the concept of normality and write the following in my field notes:

> *"Recovery / getting back to normal, why should these terms be used if childbirth is a normal event? If midwives say this is 'normal', how does this fit with women's perception of normal? Does this have an impact on how the midwife supports women with perineal pain? If the women view it as abnormal but the midwife perceived it to be a normal consequence of birth what effect might this have on the way in which midwives support women with perineal pain?"*
> **October 2002**

Women may have different views from midwives and other health professionals about what is normal. A birth that seems 'abnormal' by hospital standards could be perfectly normal by a woman's own individual standards and circumstances and vice versa (Davis-Floyd 2004). These potentially different views of midwives and women can affect the way in which midwives provide care to women. If midwives fail to recognise and acknowledge to women the impact of the consequences of perineal trauma following childbirth, then this may prevent women from receiving the appropriate care and validation of their experiences undermining women's confidence and perception of self. Fran explains that her perineum sustained a first degree tear, but questions the validity of the definition of a first degree tear being small. This is because to her it felt horrendous:

> *"I just tore with Abby 'cos that was what they said was a first degree tear which is very small isn't it? It doesn't feel that way you know. I don't know it must be something at the back of your mind, it must be a horrendous tear you know."*

Chapter 5 explores in more detail the pain women experience with perineal trauma and that a small tear does not necessarily mean less pain, a perspective that some midwives demonstrate.

Understanding normality, views and variations

The word 'normal' has been used to describe birth for centuries (Towler and Bramell 1986) and midwives are seen as practitioners of the normal (Nursing and Midwifery Council 2004a). A clear understanding of what is 'normal' is therefore important in defining the boundaries within which midwives practice as well as fundamental to their daily work and consequently the quality of care offered to women. While health professionals would agree that the well being of women and babies is paramount there are differences of opinion how best this can be achieved.

Childbirth is often described in terms of normality (Oakley 1984; Perkis 1998; Troop et al 1999). For some it is a normal physiological event where the progress of pregnancy, birth and the postnatal period is evaluated on its own merits (Royal College of Midwives 1997). Women and midwives are partners in care sharing knowledge to enable women to make their own choices based on accurate and unbiased information. Women are the focus of care with midwives listening and responding to their needs. The approach aims to increase women's autonomy over the whole childbirth experience (Department of Health 1993; Department of Health 2004). A trusting relationship is built between midwives and women, empowering women to be in control of their own birth experience. Sarah demonstrates this when reflecting on the outcome of the birth of James:

> *"I felt in control throughout the labour, definitely. (Um) definitely, although I was being instructed as to what positions to get into, I felt I was doing what I wanted to do right the way through..."*

The physiological view or model, understands childbirth as being normal until proven otherwise. Routine practices and interventions are not performed as the health of women and their babies are not defined as being at risk. Kitzinger et al (1990)

challenges further the term normality arguing there is not a single definition for normality and that it can change over time. Normality can be interpreted as 'statistically common' or as 'natural'. In the first case, normality includes such common procedures as episiotomy, artificial rupture of membranes and electronic fetal monitoring. These would be viewed by some midwives as part of normal labour and would argue that these are the responsibility of midwives. These interventions are included in the midwifery education programme that prepares midwives to enter the register in order to gain a licence to practice (Nursing and Midwifery Council 2004c). Incorporating these aspects into the programme clearly identifies them within the boundaries of normal midwifery practice. They have become a routine part of care and are performed without necessarily taking into account the available evidence to justify when the intervention would or would not be appropriate.

Alternatively, 'normal' may mean 'something that occurs naturally' – a definition that includes breech and the birth of twins but excludes the common procedures such as episiotomy identified above. Midwives in this instance would want these situations to remain the domain of the midwife and not referred to the obstetrician, as is currently the case. If the natural and common definitions were used together as part of the midwives role then midwives would need to refer to a doctor less often because their practice could include breech and the birth of twins as well as rupturing membranes and performing episiotomies. However, if midwives practiced strictly by the 'natural' definition conflict could occur as some midwives might refer women when the slightest form of intervention is necessary. This could restrict the midwives' role. If a strictly 'statistically common' definition of 'normal' was adhered to then this could mean that the midwife becomes proficient in the use of technology, losing the ability to 'use eyes, ears and hands' to support women naturally. An example of this already happening is midwives lack of skill to support women to birth with an intact perineum (Myrfield et al 1997; Stamp 1997; McCandlish et al 1998)

In contrast to the physiological model, the medical model emphasises that pregnancy and birth are potentially 'at risk' and that childbirth can only be classed as normal after the outcome is known (Bryar 1995; Perkiss 1998). Medical or mechanical interventions become important in managing any potential risk that may be detrimental

to the progress of pregnancy or labour and birth. The term 'risk' has more recently appeared in the midwifery literature, with emphasis on risk management, antenatal screening for risk of abnormality and risk criteria for midwife led care (Thomas 2003). Interventions in labour to manage such risks include induction, episiotomy and caesarean section and are performed on the basis of improving the health of women and their babies. Enkin et al (2000) counter argue this belief stating that there is some evidence that such a categorisation may benefit a few, but using the label 'risk' increases intervention with resulting morbidity for many.

Further differences between the two models can be seen in the factors that are taken into account when evaluating the outcome of birth. Successful outcomes of birth within the medical model are framed according to types of morbidity and mortality using statistics to demonstrate results. This emphasises the separation between the mind and the body as well as reducing the body still further to specific parts, such as the perineum, the uterus or the bladder. Martin (1987) argues knowledge that was previously the domain of women and midwives has become rewritten and reinvented in the image of the dominant medical model. What has been lost is 'working with the body / nature' approach, which does not fit into how medical knowledge is taught where the body is broken down into discrete systems such as the circulatory or reproductive systems. Viewing the body in separate parts has resulted in care being delivered according to the system under scrutiny rather than the body as a whole. In this context birth is viewed in isolation from such factors as psychological and social needs of women. The opinions and experiences of women are discounted in the medical model because childbirth is based on objective, scientific understanding of the causes and cures of specific disorders (Giddens 2001). Therefore, the medical model where body systems are dominant factors, determinants of successful outcomes include perinatal and maternal mortality and morbidity rates.

In contrast the physiological model has success indicators that are more broadly based including the birth experience, experiences with the mother-baby relationship and the experiences with integrating motherhood into a woman's life style, which can only be assessed over weeks or even years following the birth (Kitzinger 1972, Chalmers et al 1980). The woman is seen as a whole person who interacts with her environment and

who is influenced by many aspects (Morris 2005). The indicators of success for the physiological model demonstrate that social, cultural and psychological factors all have an influence on outcome that can impact on the birth experience well beyond the completion of birth. An example to demonstrate how these two opposing views may have an influence on the care provided to women in the postnatal period, and the importance of midwives practising within the physiological domain, is offered by Amanda. The medical model would assume that Amanda has a successful birth; her baby was born vaginally with no medical intervention, including the absence of an episiotomy, although she did sustain a second degree tear. Her baby was born alive and well. Amanda however had a different view:

> *"Mainly my emotions are disappointment that I needed stitches but the biggest one is fear – of peeing which I haven't really done properly, of how long it will take to heal and the biggest fear is that this will put me off ever having any more children."*

This example demonstrates that the outcome of birth must take into account factors beyond the physical act of a baby being born to include emotional and social factors as well. Salmon (1999 see also chapter 1) illustrates the importance of understanding the impact perineal trauma may have on the emotional experiences of women. In her research Salmon details the harrowing accounts of women still distressed 18-months later as a result of the perineal trauma they sustained. One woman tells in her own words how her vulva repeatedly had small splits following sexual intercourse. This was despite being told everything was normal when she visited her doctor and was examined, another example of the confusion that exists around the use and meaning of 'normal' and the imposition of a powerful medical definition of this on a woman who experiences this quite differently. After 18-months of suffering she finally went back into hospital to have her perineum re-sutured.

Defining normality in the postnatal period

The opposing views briefly described above are usually debated in the context of pregnancy, labour and birth, without extending to the postnatal period and

incorporating such experiences of those described by women in this study about their perineum. Despite this Anderson and Podkolinski (2000) argue that although the postnatal period attracts less attention from obstetricians, because the business of birth is complete, the philosophy that underpins the medical model is still clearly apparent through the way midwifery care is practiced. For example, the physical checklist that is used to structure most postnatal care in the UK includes examining women's breasts and nipples, rate of uterine involution, lochia (uterine blood loss), perineum, legs and urinary function on a daily basis (Marchant 1995; Magill-Cuerdin 1996). Using a check list in this way emphasises the separation of the social and emotional needs of women from the physical aspects of care provided in the postnatal period.

Studies such as the work of Murphy-Black (1989; 1994) reinforce the view of Anderson and Podkolinski (2000), identifying that care provided by midwives in the postnatal period tends to meet only the physical needs of women. Murphy-Black (1989; 1994) sought to determine if care provided by midwives met the physical, educational and psychosocial needs of women following transfer home from hospital. The study surveyed 645 women at 10 days, one month and three months postpartum. Semi-structured interviews were undertaken with a sub-sample of women. Using interviews added strength to the study. They gave depth to the responses enabling issues to be explored in more detail. There was a good return rate from the questionnaires ranging from 83 percent to 76 percent depending on which of the three questionnaires were being returned. Murphy-Black acknowledges that women not responding to the questionnaires differed significantly from those who did respond. They were socially disadvantaged (not employed, living alone, not married or living with unemployed men) and had poorer obstetric and neonatal outcomes (lower mean birth weight, lower Apgar score at five minutes old and more likely to be admitted to the Special Care Baby Unit). The findings in the study therefore, do not fully represent all the childbearing population. Significantly, the findings do not account for those most likely to be categorised as socially excluded and disadvantaged.

Findings from the women's reports of the care they received from midwives demonstrated this was mainly physical care consisting of a series of tasks. Midwives did not adjust their care to take account of the type of birth or the mother's previous

experiences of childbirth but tended instead to follow a routine related to the number of postnatal days on discharge from hospital. The educational and psychosocial aspects of the midwives' role were reported less frequently by the women and did not always meet their needs. A routine approach continues to be highlighted in the recent recommendations from the Department of Health document *National Service framework for Children, Young People and Maternity Services* (2004). The document clarifies there is still a deficit in providing postnatal care that identifies and responds to the individual physical, psychological, emotional and social needs of women.

There were occasions however, when women in my study did talk about midwives supporting more than just their physical needs. Clare for example reflects towards the end of her diary that the midwife had been very supportive, which helped her enjoy the experience of having Laura:

> *"The midwife was very, very nice, and helpful and put my mind at ease which made me a lot more confident about a few matters so I think throughout I was looked after very well and have enjoyed the experience of having Laura."*

Despite this need for a personalised response, routine approach to care is adopted by many midwives. Oakley (1977; 1993) argues that part of the reason for this is the increase in the number of women giving birth in hospital. Giving birth in hospital enabled obstetricians to become increasingly involved in the childbirth experience of women and procedures such as perineal shaving, the administration of enemas and episiotomy, developed as part of routine practice without the evidence to base such interventions on. This dominance of routine practice as far back as the 1980s is clearly illustrated by Willmott (1980) who, during her work as a community midwife recalls one professor who insisted that episiotomy was performed on all women booked under his care and any midwife delivering one of his patients with an intact perineum had to face his wrath.

Rules and standards governing the practice of midwives have been incorporated in legislation for over 100 years. Midwives must adhere to the rules, standards and code of practice set by the regulatory body or be subject to allegations of misconduct with the risk of having their licence to practice removed if they fail to do so. In the past

however, the *Midwife's code of practice* (United Kingdom Central Council 1983:9) has reinforced the routine way in which midwives worked, for example stating they 'should undertake detailed assessment of maternal progress morning and evening for the first few days after delivery and then daily'. This did not take into account the individual needs of women, their birth experience or their wellbeing. By 1991 the rules had been updated several times and the pattern of attendance by the midwife in the postnatal period had also changed. The wording was much broader - to be not less than ten and not more than 28 days (United Kingdom Central Council 1991), leaving more of the decision-making to the midwife. This was an improvement on the previous prescriptive rule of 1983 but continued to provide restrictions to the way in which midwives could meet the individual needs of women. Midwives were prevented from continuing to attend women who required midwifery care beyond 28 days with problems such as sustaining breastfeeding, or where the healing of a perineal wound was taking longer due to an infection being present. Recently, the new regulatory body for midwives, the Nursing and Midwifery Council has set more flexible rules enabling the midwife to assess the women's needs and manage her care for the period of time that is appropriate. An example of treating women as individuals is highlighted in Anne's diary. The midwife had assessed during Anne's postnatal visit, there were no problems and so decided not to visit for several days:

> *"No problems – even the midwife decided to skip the next two days, so I would see her again on Sunday."*

The decision to delay visiting for several days in the early postnatal period was not considered as an option in the previous Midwives rules set by the UKCC, as they did not facilitate individualised care enabling midwives and women to decide between them what was appropriate. Routine care therefore overshadowed the holistic approach that encompasses cultural, social and psychological assessment. At a time when many demands are put upon women, as they are learning to care for and interact with their baby, the feeling of perineal pain and discomfort could lead to resentment and low self-esteem (Kitzinger 1986).

Incorporating 'striving for normality' into postnatal care

The aims of postnatal care include promoting the physical well-being of women and their babies; meeting their psychological needs; giving support that includes health education about caring for the baby; helping to establish breastfeeding and facilitating a successful transition to parenthood (Marchant 2003a; Bick 2004). It has been demonstrated in this chapter that striving for normality is important to women following the birth of their baby. In order for this to be achieved postnatal care should be sensitive to the individual requirements of women and include social and emotional needs.

Despite the above aims postnatal care appears to have merged into routinised assessment of key factors, such as daily examination of the woman's perineum without taking into account any real understanding or knowledge of the normal range for many of these symptoms (Marchant 2004). Lack of knowledge underpinning practice is a concern expressed by Walsh and Ford (1989). They identify the increasing use of the 'procedure book' where practitioners follow a predetermined list of instructions reducing the need to have to think about the problem and work out an individual solution. This is referred to as ritualistic action. The rationale underlying the development of such procedures is frequently based on historical catastrophes rather than sound research evidence, and sometimes referred to as a 'knee jerk' reaction. It is a way of coping with uncertainty and anxiety, and to spare staff such anxiety, procedures and policies are an attempt to minimise the number and variety of decisions that must be made. This has the effect of protecting health care professionals from decision-making but does not protect the women from poor practice that is reinforced through hospital policies.

The visual inspection of the perineum by the midwife in the postnatal period is an example of such routine practice. In the past, the education and training of midwives has reinforced the notion of ritualistic practice by determining a prescriptive approach to perineal examination including, 'inspection for any bruising or oedema and if the woman has sutures, the wound is observed for cleanliness and healing. During this part of the examination haemorrhoids may be noted and appropriate treatment advised'

(Sweet 1984:247). More recent textbooks have attempted to put women at the centre of care by involving them in the assessment of their perineum and perineal function. Marchant (2003a) explains if women appear to have no discomfort or anxieties about their perineum, it is not essential for the midwife to examine this area. Women may be the first to notice signs of morbidity such as infection when symptoms like increasing perineal pain and the perineum feeling hot and becoming inflamed. Careful questioning by the midwife can assess for these symptoms, without the need to view the perineum. It is only after having the answers to the questions that if there is any cause for concern that the midwife may view the perineum. Janet identifies in her diary that the midwife checked her stitches on several occasions in the early part of the postnatal period. This is despite there being no obvious comment from Janet that there was any cause for concern:

> Day 2
> *"Midwife checked the stitches and said all ok not infected"*
>
> Day 4
> *"Midwife came out in the morning and checked stitches all ok and said tidy job"*

Warwick (2000) reflects on her early midwifery career remembering how she carried out physical examinations of women and their babies but, even then, doubted if the examinations in themselves were of most importance; rather that the interactions necessitated between the mother and midwife were the true value. This notion of interaction and listening to women is an aspect that prompted me to reflect on what the women participating in this study were saying when they were talking with me. An example from an entry in my field notes illustrates this:

> *"When listening to the tapes during transcribing, I remember thinking on several occasions that I wished the individual midwives involved in the care of the women recruited to the study could also hear what was being said. It would be an important learning process for midwives in developing their practice to meet the needs of women."* **April 2003**

Women's desire to strive for normality following the birth of their baby is reinforced by ritualistic postnatal care, where the physical symptoms are divorced from the emotional demands of the body. Concentrating on physical symptoms in the postnatal

check list misleads women by implying they will 'get back to normal' within a short space of time believing they should be able to cope with all the extra demands that parenthood places upon them, within 6-8 weeks of giving birth. Having invested women with a sick role during pregnancy and birth, the medical model pronounces women 'cured' after they have given birth: they are no longer sick and encouraged to resume normal life as quickly as possible (Anderson and Podkolinski 2000). Early in the diaries women reinforce the notion of getting back to normal quickly, as Debbie describes in her entry:

> *"Keeping this diary has made me more conscious of what my body went through during labour and birth and I think I have to work harder to return to normality because of it."*

It appears the act of keeping a diary for Debbie, provided the opportunity for her to reflect on her birthing experience including the consequences of giving birth for her perineum and pelvic floor and what she felt she needed to do in order to get back to normal (see chapter 7).

What is lost is the concept of childbirth as part of a larger psychosocial change that is occurring in a woman's life following the birth of her baby and it is this aspect my research highlights. A similar view is supported in the work of McVeigh (1997) who explores the functional status of women after childbirth and suggests there is a common assumption that after giving birth women take on the required infant care and resume self care along with household and occupational activities at the same level of commitment as before the birth. Women are not given the opportunity to adjust to the increased complexity and demands of their role as mothers. A non-random sample of 200 women from a culturally diverse population was surveyed at six weeks postnatal, using the Inventory of Functional Status After Childbirth (IFSAC). The tool was developed by Fawcett et al (1988) to assess social aspects of function following childbirth. McVeigh had a 66 percent return rate of questionnaires the results of which indicated that none of the respondents achieved full functional status by six weeks following the birth of their baby. A weakness of the study related to the non-randomisation of women resulting in a particular group of women being recruited. Diversity such as women experiencing complications and single mothers were not

included and may have led to different results. Women were also only surveyed once and a longitudinal study, starting earlier in the postnatal period may have mapped the change in functional status more clearly. However, the findings of the study provided evidence that return to full functional status takes longer than physiological recovery after childbirth. This point is clearly made by Ruth and Clare who both realised they had done too much.

Ruth:
"I think I, think I had done just too much. I was trying to be wonder woman..."

Clare:
"I feel a bit stupid but I can laugh now. I think I need to slow down a bit because I am expecting too much of myself trying to get everything done. When I was walking down town I felt a very heavy bottom and needed to sit down as I found I lost more blood when I was walking."

Price (1988) points out that efforts to 'get back to normal' may only serve to force the inadequacy and low self-esteem felt by many, as they struggle to adapt their lives to motherhood. As a culture, we minimise the impact and effect of childbirth on women.

Postnatal assessment has been further examined by information gathered during a 4-year descriptive survey by the National Perinatal Epidemiology Unit (Marchant 1995). An in-depth descriptive survey with 200 women was conducted to explore the expectations women held of the care and support they would receive in the postnatal period and of their experiences related to care and support over the first two weeks. Midwives and health visitors were also asked to complete a questionnaire about the care mothers recruited to the study received. Findings identified that some midwives attempted to offer individually focused postnatal care but at the same time continued the inclusion of predetermined examinations, identifying ritualistic practice was still taking place. A difficulty with the findings of the study by Marchant was that the women's recall of the content of the postnatal check did not always match with the content of the check midwives said they did. Undertaking a study observing the practice of midwives providing postnatal care, or asking women to keep a diary describing the care they received on a daily basis could offer more reliable information.

It is difficult to tease out from the study by Marchant (1995) why midwives practised in this way. Midwives appeared to understand the relevance of individualised care but still felt the need to include, 'what was always done'. Midwives, at the point of registration, have responsibility for and autonomy within their sphere of practice. Autonomy in this context means having freedom to act on behalf of childbearing women. Midwives work in partnership with the women and have the knowledge and capability to provide continuity of carer for women with straight forward pregnancies. Midwives also work in partnership with other health care professionals when this is in the best interest of women, their unborn child or newborn baby (Fraser and Cooper 2003). Practising in this way can be challenging to midwives who lack the confidence in their autonomy and decision-making skills. Difficulties arise when there is conflict between hospital policies, the available evidence and the needs and wishes of the women. Policies are a useful tool in providing consistency, so reducing conflicting advice (Nursing and Midwifery Council 2002). Some midwives believe they define their role more clearly contributing to ensuring safe practice.

The opposing view is that policies can restrict midwives autonomy and flexibility to exercise clinical judgement in relation to each individual woman (Garcia and Garforth 1991). A way to use the best of both views is to ensure that midwives are involved in the development and setting up of guidelines within the practice environment that they work in and ensure policies are written in such a way as to promote flexibility. Midwives need to have the knowledge to assess research and other forms of evidence to ensure practice is delivered from an evidence base. It is important to develop skills of assertiveness and professional confidence so that midwives can put their views forward and develop their argument coherently within a multiprofessional environment. These skills need to be part of the pre-registration education and training of midwives. Women who have recently used the maternity services should be invited to be members of guideline development groups to ensure the user voice is heard and outcomes are grounded in reality.

Midwives in the study by Marchant (1995) may have been portraying their frustration at the differences between their professional responsibilities to act within the boundaries set by the regulatory body, and their employment responsibilities set out in

their contract of employment. The dilemma occurs when for example, midwives' judgements on an individual woman's care is at odds with the hospital policy and if midwives act upon their clinical judgement they may be in breach of their contract of employment. However if midwives were able to evidence their decisions for the benefit of the women and justify why they were omitting certain aspects of routine care, and document their reasons, then they would be practising within the ethical code set out by the regulatory body (Nursing and Midwifery Council 2004b). Janet offers an example of how evidence was considered by the midwife and shared with her but left the decision for Janet to make:

> *"my friend just came in and said, you know give it a go (putting salt in the bath), I gave it a go...but then the midwife in the hospital said, oh you can try it if you think it might help but research has shown that it really doesn't do anything. You would be better just having a normal bath (um)."*

The Audit Commission (1997) reported that while postnatal visits by midwives were popular with women the purpose was largely unspecified. There was no evidence of their clinical effectiveness or whether they detect health problems now known to be commonly experienced including perineal pain, urinary incontinence and constipation. All of these symptoms were common complaints described by the women in my study (see chapter 6). Part of the function of the Audit Commission is to carry out studies to make recommendations for improving economy, effectiveness and efficiency of services. This purpose needs to be borne in mind when evaluating any research outcomes, demonstrating possible biases in recommendations that are eventually suggested as policy reform. Where important data are not available from other sources, the Commission undertakes original research. The study surveyed a nationally representative sample of 2300 women via a postal questionnaire regarding the nature of the care they received during pregnancy, labour and birth and the postnatal period. On the whole women were satisfied with the way they felt they were treated and were pleased with the care, but it was identified that services could be improved. Significant financial savings could be made annually if consideration was given to re-organising maternity care by making changes to bring in evidence on clinical effectiveness into routine practices.

The Audit Commission (1997) recommendations have been the basis for developing postnatal services in a Sure Start area in the south of England (Wilyman-Bugter and Tucker 2004). Sure Start is a Government programme, which aims to achieve better health and social outcomes for children, parents and communities (Sure Start 2006). The Sure Start local programme wanted to develop an effective system for identifying, assessing and treating the physical problems experienced by women during the postnatal period such as continuing urinary incontinence. The programme members were aware of the available evidence recognising the physical changes faced by many women during the first months following the birth of their baby and that a vast majority do not seek support for sometimes chronic debilitating problems (Bick et al 2002). The project led to the development of a model of service delivery, including the use of evidence-based guidelines, and the establishment of a designated postnatal clinic run by a multidisciplinary team. The clinic has the capacity to see three women a week and is staffed by an obstetric registrar and physiotherapist. In the initial nine months of the programme being set up 40% (n=26) of women seen at the clinic were referred for problems relating to perineal pain. The early detection and preventative role of the clinic has identified that the physiotherapist is able to see women much earlier than before, reducing the amount of intervention required to treat the condition. The challenge remaining for the Sure Start team is to ensure the service is integrated into the mainstream maternity service.

The Audit Commission survey (1997) is due to be repeated in 2006. This will provide a useful comparison to identify what, if any improvements have been made, from the perspective of the women.

Summary

This chapter identifies that returning to normal following childbirth is significant for women. However the term 'normal' raises questions about whose normal is being referred to. There are two opposing philosophical domains that place childbirth either as being inherent with risk, or a process that is normal until proven otherwise. It is the latter that professes to encompass childbirth as a whole experience taking account of

physical, social, cultural and psychological needs. These aspects have been demonstrated to be important for women in my study who sustain perineal trauma with the birth of their baby. The opposing philosophical domains of childbirth have created dilemmas for midwives who argue that they are practitioners of the normal but due to a history of medical dominance and routinised care it is questionable how frequently this occurs. This confusion has not been helpful to women as postnatal care has been dominated by routine practice associated with checking body systems such as the perineum, urinary system and gastrointestinal tract rather than supporting women holistically to meet individual needs. The views of women and the impact of childbirth on their health and recovery have failed to be encapsulated by midwives in the care given to women.

The following chapters identify what 'striving for normality' means to the women in this study and what midwives can learn from this.

CHAPTER 4
PREPARING FOR THE UNKNOWN

Introduction

In the previous chapter 'striving for normality' was identified as being significant for the women who participated in my study. It was questioned whether the notion of normality was the same for women as it was for midwives and doctors. This chapter explores how the women prepared for the impending birth and the experiences they were anticipating. The following two chapters identify how closely the anticipated experiences matched the reality and discuss adjustments women made to cope with the deviations from the expected in order to return to their 'perceived normality'.

While preparing for the birth, women built a picture of what they did and did not expect to happen during the birth and subsequent postnatal period. Part of this picture included the extent to which any damage may occur to the perineum. Women having their first baby expected a normal birth without intervention but in reality their expectations were not always realised. This often left them unprepared for example, for the impact perineal trauma would have on their ability to carry out bodily functions and normal daily activities. For all women in my study having a second or subsequent baby, preparation for the birth and early postnatal period included drawing on their previous experiences. However, the reality again was different, this time being better than expected because the birth outcome and subsequent perineal pain and discomfort were not as bad as had been imagined.

For many women expecting their first baby, childbirth is an unknown experience. Nolan (1998) a skilled antenatal educator with the National Childbirth Trust, explores preparing people for an unknown experience. She discusses how women today, giving birth for the first time, are unlikely to have helped other women in labour or been present at a birth, a very different experience from their great grandmothers or grandmothers where this was often the norm. Today women prepare for birth in different ways such as attending classes, talking with family, friends and work

colleagues as well as reading books, magazines and using the Internet to gather the information they require (Blakey 2003; Marchant 2004). These methods were common to the women in my study demonstrated by the following examples:

> Fran:
> *"I was searching the internet...and they were saying things like Witch hazel spray you can spray on (to the perineum following birth)..."*
>
> Janet:
> *"We just did the antenatal classes at the doctor's surgery."*

Attending preparation classes

Preparation classes held during pregnancy have developed over the past 30 years, attempting to meet the changing needs of women and their partners. Information is provided about fetal development, keeping healthy, preparing for the birth and baby care in the postnatal period. Initially classes were set up to teach skills about baby care and were known as mothercraft classes. Up until the 1950s women were usually educated in the home by health visitors until hospital birth became the norm, when antenatal education became part of the midwives role (Nolan 1998). In more recent years the style, content and presentation of information have been updated to reflect the differing needs of women as their role in society changes. For example, many women now work during the day so classes in the evening are offered, which also suits those who wish to attend with their partner. The presentation of information has become more interactive reflecting what women have become accustomed to via television and the Internet (Murphy-Black 1990). Adult education theory, such as the work of Carl Rogers (1983) has also influenced the way preparation classes are structured and information is shared. The education of adults requires different approaches from teaching children, moving away from didactic presentations with limited participation where women and their partners were talked to. Instead a more facilitative approach of discussions about topics that are generated from the women themselves is used. Preparing the environment is also important, where chairs are arranged in semi-circles,

not rows and tea and coffee are available to enhance a relaxed atmosphere that is conducive to learning (Macdonald 2004).

There are a variety of preparation classes available that are run by midwives and other health professionals that take place within the National Health Service (NHS). There are other classes organised by independent groups such as the National Childbirth Trust, where trained antenatal teachers (who must have experienced birth) and breastfeeding counsellors (who are required to have breastfed their baby) run the sessions. In these instances the people running the classes are not necessarily midwives. The original aim of the classes organised by the National Childbirth Trust was to offer a different approach to the medical model of care that women perceived was being taught by midwives in the NHS. The approach taken by the National Childbirth Trust has been mirrored by other childbirth educators who aim to empower women to trust in their bodies and in their natural ability to give birth to their babies. The aim is to help women replace the medical model of birth, in which the mother is passive and her carers manage the labour, with a dynamic model where the mother is active and in control (Nolan 1998). Teaching pelvic floor muscle exercises for example is a way in which women can be made aware of the muscles that will be involved at the time of giving birth. As the baby is born through the birth canal women can apply the knowledge they have gained to use these muscles effectively during this time. Practising pelvic floor exercises during pregnancy may also help to remind women to continue the exercises once the baby is born (see chapter 6).

Midwives have an essential role in assisting women and their partners to prepare for the demands of pregnancy, labour, the puerperium as well as parenthood (Royal College of Midwives 1999; International Confederation of Midwives 2005). Preparation should include not just physical aspects but broader issues of education related to baby care, parenting and relationship changes. Spiby et al (1999) have a similar view identifying that information about the childbirth process, and choices available for labour and infant feeding, should all be part of the aims of antenatal education. Rees (1996) refers to several studies that identify the social function of classes. Preparation classes can be an ideal opportunity for prospective parents by bringing people in a similar situation together to learn from each other. Good antenatal classes provide an introduction to

peers who can exchange information, discuss anxieties and learn from each other (Schott and Priest 2002). Spiby et al (1999) and Blakey (2003) also recognise the importance of providing opportunities to meet other women in the same situation, which would facilitate the forming of new relationships and supportive networks. Social support is important especially when taking into account Nolan's (1998) comments that women lack understanding of the childbirth process, not knowing what to expect or how to prepare. If women or their partners do not have parents near to hand, or the family bond is not very strong, supportive networks can be beneficial (Schott and Priest 2002) and friendships are often formed that last for many years (National Childbirth Trust 2006).

The information women want and need in order to prepare for the birth and afterwards are variable, depending partly on prior knowledge and experience as well as expectations. It can be difficult for class leaders to meet all the needs of the women. Some individuals will want to know absolutely everything, while others do not want to hear 'anything gory', a point illustrated by Sarah and Hannah.

Sarah:
"If someone had said to me you are going to be cut, and you are going to bleed quite heavily and you're going to need really strong pain killers and find it difficult to feed because sitting is going to be a problem, then I could have coped with it more."

Hannah:
"Probably best nobody did tell me all the horrible bits, (having stitches), that would have made it worse."

Janet also commented that at the classes she attended they had not been told how long the process of stitching a perineum would take and what it actually entailed:

"... they didn't explain that you have your legs up in stirrups and it can take an hour after the birth and all of that. They said about being cut and having stitches and having to get over the stitches but not what that entails, you know. An hour after the birth you will be like this and you have to have your husband and a midwife actually grab hold of your legs and move them for you because it is so painful you have been in the position for so long."

Janet's request to know the detail of what happens when the perineum is being sutured may not suit everybody and again identifies the difficulty of meeting the needs of all those attending the class. However, Janet felt she would have benefited from this knowledge, as it would have helped her to prepare for what to expect. The position Janet describes while having her perineum sutured is called lithotomy and is explored in more detail in chapter 5.

Studies researching the effectiveness of preparation classes have identified that information about the postnatal period is lacking (Ockleford et al 2004) despite it being an acknowledged aim of antenatal care. Hayes et al (2001) argue that failures have been identified in dispelling unrealistic expectations, and little time allocated to considering what happens after the birth. When classes do refer to what happens after the birth it relates too much to the baby and not enough on the feelings and experiences of the mother (Ward and Mitchell 2004). Unrealistic expectations led to women in my study having a false understanding of the impact birth had on their body and therefore the ease, or otherwise, in being able to carry on with daily living activities as before. Preparing women for individual experiences can be difficult and inevitably not everyone's needs are met. This can be hindered when class leaders often have little or no time to prepare, teach in poor surroundings and may face classes of up to 30 couples at a time (Kelly 1998). These difficulties present a challenge for midwives trying to get the balance of information right. To help it is worth considering the timing of when information is given, as everything may not need to be covered before birth. There may be merit in leaving some topics until after the birth, especially as labour for many women, according to Tinsdall (1997) is all they can focus on, finding it difficult to think beyond this goal. Sarah illustrates this point but also reflects that she had already made up her mind how her labour and birth would progress and so did not feel the need to pay attention to information that would not achieve that outcome.

Sarah:
"I had actually planned on a water birth and I was quite adamant that it was going to happen. Actually I think from the word go I was quite confident I could deliver in the water... I didn't even listen properly when they talked about caesareans... I was only ever paying any attention when they were actually taking about labour and the water birth, and gas and air and (um)... I'm not

saying I didn't listen 'cause I did listen, but I sat there the whole time thinking I won't need that, that won't be me (laughs)."

Making a conscious decision about what will happen is not unusual as studies indicate that most women have made up their minds about issues such as pain relief in labour and infant feeding long before they come to classes (Office of Population Census Surveys 1992; Nolan 2000). Janet and Sarah were expressing confidence in their own bodies to give birth, an approach that many current birth preparation classes adopt and try to enhance. Pain in labour is talked about in terms of 'pain with a purpose' or 'positive pain'. Schott and Priest (2002) use this approach to try and reduce fear by helping women and their partners understand that, unlike all other pain, the pain of labour does not signal damage or harm, but in most cases is completely normal. Viewing labour pain in this way aims to promote normal birth, encouraging women to think in terms of 'working with the pain' and drawing on their inner strengths to give birth without intervention (Leap and Anderson 2004; Weston 2004). To sow any seeds of doubt by discussing issues related to an intervention, such as an epidural for pain relief, or an episiotomy to help the birth of the baby, may have a negative impact with women believing that they have no control over events and so learn to accept that it will inevitably happen (Sherr 1995).

However, if the potential consequences of birth are not discussed an unrealistic picture of birth and the postnatal period can happen, as Sarah explains:

"...you don't think about, in the lead up to the labour you don't think about what's going to happen to you afterwards, you just think about gosh you are going to have this wonderful baby".

The picture Sarah has of what it would be like after giving birth reinforces the notion that being able to carry on the same as before giving birth, with simple tasks such as walking and sitting have not been contemplated.

Amanda, unlike Janet and Sarah, wanted to keep an open mind about what could happen during her labour and the birth. Consequently Amanda consciously made the decision not to write a birth plan. Birth plans refer to a variety of ways in which

women's requests for what they would and would not like to happen during labour may be recorded (Green et al 1998; Whitford and Hillan 1998). They are seen as a quick way of helping the midwife understand what kind of birth would leave women feeling most satisfied and whether there are any particular cultural or religious issues that are important to them. In situations where midwives and women are able to sit down together and discuss preferences before labour, birth plans provide a useful platform to negotiate a plan for labour and birth (Nolan 2001). Birth plans however have also been criticised for being inflexible and creating unrealistic expectations about choices. They have also been regarded an irritant to the health professional because requests by the women are sometimes felt to be inappropriate (Jones et al 1998; Robinson 1999). An example of this would be women requesting not to have an episiotomy unless necessary, with many midwives resenting the idea that they would perform an episiotomy without a reason. What some midwives may not have realised is that the evidence they are basing their practice on is not up-to-date (see chapter 1), whereas the women are aware of the recent evidence and so want to make sure they are not exposed to unnecessary intervention.

When Amanda reflected on her reason for not writing a birth plan she realised that she still had an expectation in her mind of what would happen:

> *"I deliberately didn't write a birth plan 'cos I thought when I get there I'm just going to be guided by whoever, (um) but I think it was always in the back of my mind that I thought well, I will cope with it you know, I can do this, its mind over matter and I think I did have an expectation how it would be..."*

The above vignettes identify that learning about perineal tears and episiotomies during antenatal preparation classes was not relevant to meet the needs of women recruited to my study. This raises a complex question because, as my study shows many of the experiences women had related to their perineum following childbirth were unexpected and problematic. Levy (1999) found similar results in her study mapping the processes involved when women make informed choices during pregnancy. Using a grounded theory approach, data were collected by means of focussed interviews and observation. The core category that emerged from the data was 'maintaining equilibrium'; where women sought and dealt with information in such a way to keep in balance the interests

of herself, her baby, her partner and others, during a period often involving considerable change. 'Regulating information' was a category identifying where women often tried to avoid receiving information if they regarded it as irrelevant to their situation. Although the study Levy conducted related more to making decisions about antenatal care such as whether to take up the offer of antenatal screening or not, it does concur with my study that women want information that is relevant to their needs at the time.

Early contact in the postnatal period on a one-to-one basis may be more beneficial in explaining the outcome of the birth and its consequences rather than being told about it before the birth. Sharing of experiences may be helpful in the early postnatal days if women are together on a postnatal ward. If this is skilfully handled by the midwife then women would realise they are not alone with their experience and can share tips that were found to be helpful. Sharing first hand experiences is becoming less common in hospital postnatal wards as many women spend less than 48 hours before being transferred home. Talking about experiences takes place more frequently during pregnancy when women attend preparation classes. For example, women who have recently given birth and are breastfeeding may be invited to talk first hand about their experience to women and their partners. In some cases this may also coincide with the baby breast feeding, enhancing a positive image of this method of feeding. Sharing experiences for Fan however, was something that she felt would not be particularly useful to other women, and could even cause anxiety:

> Fran:
> *"I didn't really want to say anything because my experience of stitches was horrendous as far as I was concerned, so I didn't. There were a lot of first time mums there, so I didn't really want to speak up about that."*

The apprehension that Fran expresses identifies how experiences may not be discussed; however relevant they may be, in case of upsetting others about the reality of what happens. By not discussing the reality can leave women ill prepared, as described by the women in my study, for the changes that may happen to their body and any pain or discomfort they may experience in achieving relatively simple functions such as passing urine.

Despite a variety of classes being available to women having their first baby who participated in my study, they remained unprepared for the reality of the outcome of their birth and the impact it would have on them during the postnatal period. Women's perception of normality was related to a straightforward birth without intervention and an intact perineum. Information that did not match their aspirations was seen as superfluous to their needs. Following birth women recognised they should have been more attentive as they found the perineal pain and discomfort a shock they were not expecting. The challenge for midwives is to find ways of preparing women for an unknown experience, in the context of women's ambivalence about 'irrelevant' information prior to birth.

Preparing second time round

The women in this study who were having their second or subsequent baby tended to have a more open mind about what would happen this time round during the birth and in the postnatal period. Georgina explains how her experience of having three other children prepared her for the possibility of sustaining another perineal tear:

> *"I think it is more of a shock anyway, when you have your first one. So I suppose in a way, the memory of the three (um), in one way you expect it to be as bad with the tearing, but in another way it doesn't shock you the way you feel, because you have been through it before."*

Women basing their expectations on previous experiences is a finding supported by Green et al (1998). The study explored the accuracy of two contrasting views about women's involvement in the care they receive during childbirth. The first is that many women prefer to hand over responsibility for their care to the professionals who are looking after them and do not wish to take an active part in planning their care or making decisions about it. The second is that women wanting to be fully informed and in control of their care. In order to consider these two opposing beliefs 1150 questionnaires were sent to women in the antenatal period asking about their hopes and expectations of childbirth and were followed up in the postnatal period to see if these

were realised. There was a good response rate of 73.5 percent (n=842). The follow up postnatal questionnaire had a 96 percent response rate from the original 842 women recruited to the study. One of the strengths of this study was that women having a second or subsequent baby were included. It was found that this group of women were more aware of the realities of giving birth and that they had learnt from their previous experience. However, the analysis of the data was not able to extrapolate clearly what the learning was and therefore the implications it had for future practice. In my study it was possible to determine that the women giving birth to their second or subsequent baby found the experience better than when they had their first baby, as Fran summarises:

> *"I can't help thinking how much easier this one was comparing to the two with forceps which were much more painful to move and sit."*

The prior knowledge and experience women have when preparing for their second or subsequent baby suggests that their needs may be different from women having their first baby. An example of this is shown by Hannah's comments about the class she attended:

> *"I think I was a bit unfortunate, everyone in the class was on their second baby, or third baby. So again I was a bit disadvantaged that everyone kind of knew what they were doing anyway...there was nothing like that (how to cope with having stitches)."*

Hannah also reflected on her experience of the early postnatal days and likened the knowledge she had now gained, to going on holiday:

> *"...little things about knowing what to take into the hospital really. Where as now, I wouldn't need to think twice. Where as at the time I was really stuck, trying desperately to find out what to take, and sods law it wasn't the right thing anyway. So now, now everything would be considerably easier."*

Gaining knowledge through experience reinforces the difficulty of preparing women for an unknown experience; you don't know what you don't know until it happens.

One way to accommodate the differing needs is to hold separate preparation classes (Scott and Priest 2002). For women having a second baby the content would relate more to refreshing the memory about aspects of labour, but not include baby care, for example. This forum may also be helpful for women to share the experience of their previous birth, which may include unresolved issues about perineal trauma (Schott and Priest 2002). This would also address Fran's concerns about not wishing to share how painful her previous episiotomies were to women having their first baby. There are disadvantages to holding separate classes. This may deny women learning from each other, for example women with experience of birth sharing helpful information. In order for a midwife to address the needs of a group with multiple requirements she needs to be skilful in facilitating group sessions, ensuring all individuals are involved and the content was relevant to all in the group. The early evaluation of sessions by the midwife provides vital information to assess how well the needs of the women are being met and if any up-dating is required.

Ensuring midwives have the skills to facilitate large groups with diverse needs has implications for pre-registration programmes that educate students to qualify as midwives. Although incorporated as one of the competencies that students must achieve at the point of registration, the range of experience students will be exposed to will differ across the United Kingdom depending on the profile of the local community.

Friends and work colleagues

Classes offered by midwives were not the only resource women used to access information. Often friends were approached. Georgina shared her previous experiences of childbirth with two of her friends:

> *"I've got two friends at the moment who are expecting and er, we chat quite a bit about the birth process and whatever is of interest, you know people who are in the same boat. It's interesting, it always interests the other woman who's had children to talk about that because it's some big part of their life they've been through."*

This can have drawbacks, as the information passed on may not be accurate or current (Blakey 2003). The information may also suggest a standard that other women feel they have to achieve, as Amanda experienced:

> *"Then you talk to people and particularly one friend of mine who had a baby in February and she had her first baby and had a really short labour (um), just had the gas and air and she came out and it was like, oh it was great, only had gas and air, a tiny little tear that didn't need stitches. I almost felt that was something I had to live up to."*

Amanda's experience of knowing about a friend who gave birth without requiring stitches to her perineum pressurises Amanda to want to achieve something similar. If this expectation is not realised it could lead to feelings of disappointment and low self esteem by not 'doing as well' (see chapter 7). In turn this could affect how Amanda returns to her 'perceived normality' if the changes within her body are greater than had been anticipated.

Hannah had also listened to friends who told her the birth and early postnatal period 'wasn't that bad':

> *"... they've all said (um), that it wasn't bad which I think is a complete lie (laughs), it hurts a lot more and I can't imagine that I will ever forget that."*

It is evident from the above examples that for the women participating in this study, friends are not always helpful in preparing women for the reality of what to expect, but do play an important role for women in developing their expectations. Midwives need to be mindful of this and when exploring the hopes and expectations women have it would be helpful to understand who, if anyone has influenced their thinking. The accuracy of any information can then be tested and where necessary up-dated enabling women to have an informed understanding on which to base any decisions.

It was not just the women's friends who were a source of information as Amanda's husband found out to his surprise when he was offered advice from his work colleagues:

> *"He (husband) came home and says 'do you know, it's funny, everybody that has had a baby when you give them the opportunity, they will want to talk about it'. Because the girls at work were sort of telling him about when they had their children, and oh has Amanda had this or has she had that, or does she find this, and we both said it is something that you need to have to experience or really want to experience before you'll start to talk about it."*

Cultural values play an important role in the way in which pregnant women are perceived and responded to by society. Some cultures, such as those in the western industrialised societies, like Britain, see pregnancy and childbirth as a matter of public concern (Yearley 1997). Women can become public property by being talked about and given advice without asking. As in Amanda's experience, there seems to be an unwritten rule that pregnancy grants permission to allow other women to talk about their own birth experiences, something that they may never have done before. This can be equated to joining a club for example, where knowledge is shared and advice offered to rectify common problems, similar to Amanda's experience:

> *"so we (Amanda and work colleague who was also pregnant) used to sit in the coffee room at lunch time and we would be like swapping little anecdotes about has this happened, or has that happened and would be asking her all about this, that and the other and everybody else used to join in who had babies."*

Bainbridge (2006) explores the analogy of 'joining the club' from her own experience of being pregnant. She clearly remembers the positive feelings she had when people in the street would spontaneously grin at her as they caught site of her 'bump'. Since then she also has become one of those strangers and always smiles at pregnant women. Bainbridge believes the smile is a silent acknowledgement, a way of saying 'welcome to the club', and a way of remembering just how it felt to be pregnant.

Media sources

With pregnancy and childbirth being a relatively public affair, media and consumer input has taken on a high profile. Books and magazines have become a source of information, as has the Internet (MIDIRS 1997). The Internet is one of the fastest-growing sources of information on a wide range of health issues and there is a growing body of literature that indicates women are turning more and more to the Internet for health information (Lagan et al 2006). Fran used the Internet after the birth of her baby because she felt she had not been given enough information about how to look after her stitches:

> *"I was looking at the Internet, like days, weeks later and they were saying things like hazel. Is it hazel? Witchazel spray you can spray on, but I didn't know you could do that or not at the time. But anything like that would have been quite nice, whether it would've been soothing or a local anaesthetic (laughing), or something like that."*

Lagan et al (2006) undertook a review of the published and unpublished literature to provide an overview of the evidence on the use of the Internet by women in pregnancy and childbirth. The literature was reviewed through a structured process of identifying key words to search the relevant databases from 1 January 1995 to 31 July 2005. The search was limited to articles published in English and those directly relating to the use of the Internet by pregnant women. Eighteen papers were identified as relevant and were graded according to type and quality of research using the evidence categories employed by the Department of Health in the National Service Frameworks. Validity was enhanced by the analysis of the data being undertaken by one of the authors and then cross-checked by two further authors, who independently assessed each selected study for methodological quality and relevance. The study revealed that in pregnancy women used the Internet to seek social support from other pregnant women and to research specific problems, for advice on home remedies, to take part in discussion groups and for information on antenatal tests for birth anomalies. The researchers acknowledge that the papers included in the review were generally descriptive lacking in the depth of analysis that would have improved the quality of the paper. There were only a few of a size and quality to enable findings to be generalised. The study does

however identify that women use the Internet as a source to collect information they view as relevant to their needs, and midwives need to be aware that this is a medium women engage in.

Georgina knew from her previous experiences of birth that she wanted to try and help her body recover and assist the healing process, so as a consequence she read up on alternative therapies to use during this pregnancy to help during the postnatal period:

> *"...I used raspberry tea and things like that, anything to try and help. You know, since the birth I have taken Vitamin E, things like that to try...to try and help my body recover."*

However, media sources may also give a biased and unbalanced view about birth and as Henley-Einion (2003) argues newspapers, magazines, current affairs programmes and talk shows on television tend to sensationalise and standardise birth and present a view of this experience that is based on a medical model of care (see chapter 3). For example the media might focus on the birth that 'goes wrong' and how the obstetrician 'steps in' with technology and medication to 'save the day'. Henley-Einion (2003:181) cites the article that Kitzinger (2001) writes in the *Daily Mail*, which succinctly illustrates ways in which women are pressured to undergo intervention without being fully informed. Instead of it being incorporated as mainstream news it is assigned to the *Femail* section of the paper, which reflects the audience the editor sees would read it. In Henley-Einion's view, this trivialises the issue and makes it little more than 'girl talk'.

Supporting the views above, Williams and Fahy (2004) analysed in their study the techniques used to present interventionist, medicalised birth as 'normal' thus preparing women to play an unexpected passive and subservient role. The study analysed one birth story in-depth by using semiotic methods adapted by Ellen McCracken for use in feminist research. McCracken's adaptation of semiotic methods makes it possible to research the strategies that women's magazines use to create popular meanings and emotions in the reader. Semiotics begins by decoding the 'sign' by decoding the 'signifiers' that have been used to create the 'sign'. The semiotic decoder is the researcher. Williams and Fahy give an example of how this works by using a picture of

a diamond ring on the left third finger of a model. The diamond ring carries cultural specific meaning like 'commitment', 'love' and 'permanence of relationship'. The 'signifiers' include the diamond itself, size, colour the model's hand and any text overlaying the picture. All these factors create meaning within the mind of the consumer of the magazine. Analysis of the featured article about a well-known television presenter, who was pregnant, portrayed a number of elements. The image suggested a happily married, pregnant woman that someone could model themselves on. It also relayed a message of someone who was socially valued, financially secure and middle class. The text drew out the presenter's ability to work, be successful, complete her role as a married mother as well as identify her compliance with medical intervention, which promised a pain free birth and a healthy baby. What was missing from the article was a balanced and holistic representation of childbirth and midwifery care was marginalised. Williams and Fahy suggest that midwives need to be aware of how the media portrays childbirth and influence journalists in a friendly way to get the message across that there are other options for childbirth other than following a medical model. The portrayal also emphasises the ease at which the woman took on the role as mother and recovered from her childbirth experience. Women reading the article may therefore expect the same of themselves when they give birth to their baby.

The approach Williams and Fahy (2004) used to analyse the data within the magazine is different and one that is not often used to provide an evidence-base for midwives to develop their practice by. It does however offer a powerful message about how easy it is for the media to portray a particular, and often unbalanced message. Unless midwives are aware of what women are reading as part of their birth preparation and subsequent baby care then sometimes the distorted messages would continue.

It is evident that women use a variety of resources to try and meet their needs. Women having their first baby are preparing for an unknown experience and may not know what these are. Fran sums this up:

> *"I just think you can't really describe it (stitches) until you've actually gone through it, really. I don't think there is any way I could have been prepared for it with my first."*

Summary

An insight has been provided into how women prepare themselves for the coming birth and postnatal period, illustrating the differences depending on whether it is their first or subsequent baby. Women attend preparation classes that cover a wide variety of topics; they talk to friends and work colleagues as well as read relevant magazines and books. Women having a second or subsequent baby draw on their previous experience to help in their preparations. How women decide what information they require relates to their perceived needs at the time, and does not necessarily include anticipating future needs following the birth of their baby. My study found particularly that women having their first baby were not expecting to sustain perineal trauma and because of this were ambivalent about listening to this information when talked about in preparation classes. This study has therefore failed to dispel unrealistic expectations with little consideration to what happens after the birth. The lack of understanding about what to expect after the birth alters the women's perception of returning to normal quickly. The literature suggests that for several years women have commented that classes focus too much on the baby and not enough on the feelings and experiences of the mother. It is clear that multiple needs are experienced and responses required. These needs impact more fully in the postnatal period than at other times. Preparation for complexities and uncertainties of childbirth, when everyone's experience is different is a challenge that midwives need to meet if women are to be prepared. The difficulty that this presents adds weight to the importance that women are appropriately supported in the postnatal period when their experience becomes a reality and their return to normality is more difficult than originally expected.

The next chapter explores the unexpected experiences women had related to their perineum following the birth of their baby and the resulting perineal pain and discomfort, which has an impact on their need to get better and strive for normality.

CHAPTER 5
EXPERIENCING THE UNEXPECTED

Introduction

This is the second of three related chapters exploring the expectations women had of the process of birth, with perineal trauma being the crucial and central aspect, in turn having major implications for women rippling out into, and impacting on many key aspects of their world and selves. In the previous chapter difficulties with preparing for the consequences of giving birth were explored, highlighting that women in my study were often not prepared for the reality of perineal pain and discomfort. This chapter provides insight into how the reality of perineal trauma and subsequent suturing of the perineum, as well as the intensity of perineal pain was a deviation from the expected experience.

The unexpected for women having their first baby began when the outcome of their birth was not as imagined. This meant expectations and realities failed to match, and women therefore had to find ways of managing this discrepancy.

> Hannah:
> *"Was this expected? Bizarrely no! Thinking about it now I cannot understand what I thought it would feel like. Obviously I was under no misapprehension that actually giving birth would be painful although how much I had no idea. I had never given it any thought to how I would feel afterwards."*

Some symptoms had been expected, such as pain, but the intensity or severity of the pain was often unexpected. This affected how the women carried out bodily functions as well as continuing with their daily activities, especially as sometimes it was the bodily functions such as passing urine that caused the pain (see chapter 6). MacVane Phipps (1999) in a study that explored women's perception of pain in the early postnatal period highlighted the lack of information provided to women on the reality of pain following a straightforward birth. She argues that the available literature concerning women's experiences of pain following a normal vaginal birth is a neglected area of midwifery care. Whilst pain relief in labour assumes a high priority

the very real discomfort that some women suffer in the first few days following the birth surprise women, and go unrecognised by midwives providing postnatal care. Semi-structured interviews were used with six women three days following the birth of their baby. It was found that post-delivery pain had a major impact on the women who experience it, and that not enough antenatal preparation was given to this aspect. Women also felt they were not taken seriously about the pain they felt. As the number of women recruited to the study was small the findings should not be generalised but it does give a useful insight into the experience some women had of perineal pain after the birth of their baby and similar to findings in my study. The findings by MacVane Phipps and supported by my study suggests that more research is needed in this area.

The experience of being stitched

Two studies supported by the National Childbirth Trust (Kitzinger and Walter 1981; Greenshileds and Hulme 1993) collected information relating to women's experiences of having their perineum sutured. Although not specifically requested in the latter study, some women felt compelled enough to write about their experience. Both studies acknowledge that samples were entirely self-selecting and may not reflect the views of all women giving birth, as those who had a particularly difficult experience could be more motivated to respond to the surveys. The early study by Kitzinger and Walter was the first to draw to the attention of health professionals the distressing experience women had of their perineum being stitched. As highlighted by Sarah in my study, similar experiences are still being expressed today:

> *"The registrar has really scarred me emotionally with her manner in which she dealt with me. Her bedside manner was non existent and I felt that she did not explain anything to me about what she was doing – and added to my fear and caused me extra distress."*

The above description articulated by Sarah confirms the importance of communication between the woman and the health professional (in this case the obstetrician), to provide information about what was happening, and what to expect before it is carried out. The manner in which Sarah recalls the Registrar spoke to her is inexcusable and

highlights the need for women to be knowledgeable about how to complain about poor practice. Complaining and then receiving an apology is considered a means by which an individual's poor experience is acknowledged and helps to put the experience behind them. All NHS Trusts in England have a Patient Advice and Liaison Services (PALS 2006), which is a Government initiative that provides confidential advice and support to patients, families and their carers. PALS offers confidential assistance in resolving problems and concerns quickly and explains the NHS complaints procedures and how to get in touch with someone who can help. PALS has a leaflet which should be widely available to all people who use the NHS and in the case of women using the maternity services, the leaflet needs to be prominently positioned in all areas and given to women by the midwife who visits them in the community. Appropriate communication is one of the recommendations offered by Salmon (1999) explaining that midwives and doctors failed to hear women's concerns or actively respond to them. Health professionals need to learn to listen to women as in Salmon's view, this would have made a qualitative difference to the experience women described. A difference between one of the outcomes of Salmon's study and experience that Sarah describes is the gender of the obstetrician. In the study by Salmon the fact that the obstetrician was male made the experience worse for the women as they were being dominated by a man. The obstetrician who sutured Sarah's perineum was female, and although Sarah did not express feelings of being powerless or dominated she was still left emotionally scarred.

The experience of being in pain while having perineal stitches inserted was a common experience for the women in the study by Kitzinger and Walters' (1981). They found that approximately 23 percent of women who had their perineum sutured found the experience painful or very painful. A later study by Green et al (1998) found little improvement. This large prospective study (n=710) by Green et al of women's experiences of childbirth found the process of suturing was still a major and sometimes traumatic event for women. The pain of suturing was a particular issue for two thirds of the sample with 19 percent of women describing 'a lot of pain' during stitching suggesting that pain relief methods were inadequate or that insufficient time was given for drugs to take effect. Greenshield and Hulme (1993) report a similar finding where

12 percent of women found suturing the worst thing about their birth. Sarah echoes these points explaining why she felt the experience to be so painful:

> *"I thought at least the Dentist gives you the courtesy of prodding you first to see if you're numb, and can feel that, but there was none of that. She was quite (slowly chooses word) barbaric."*

The time between giving birth and the perineum being stitched is an issue raised by Moyzakitis (2004) for consideration. Moyzakitis explored women's experience of distress and / or trauma in childbirth to try and understand how women describe and make sense of their experience. The data were analysed and grouped into categories of general headings that held similar themes. Four major themes emerged from the data analysis: 'role of caregivers', 'impact on self-image', 'impact on relationships' and 'severity of the experience'. The theme, 'impact on self-image' identified that women felt alienated from 'self' and the birth because of the disempowering environment they were being subjected to. Some women developed strategies in order to preserve the integrity of 'self', such as 'blanking out'. An example is given of a woman pleading and screaming with the health professional undertaking the suturing of her perineum to stop for a few minutes while she could compose herself and calm down. The woman was ignored and eventually she remembered 'blanking out' (words used by the woman). Blanking out in this context meaning 'disassociated', which is a term often used as a response to major trauma.

Moyzakitis (2004) suggests that for some women there is a need for choice about being routinely sutured immediately following the birth. Although the study sample is small (n=6) so the findings cannot be generalised, midwives should consider Moyzakitis's suggestion of giving women choice from an appropriate evidence-base. There is evidence (National Institute for Health and Clinical Excellence 2006) that identifies the perineum should be sutured as soon as possible after the birth to reduce blood loss and the risk of infection. Midwives need to balance the immediacy of any risk, such as haemorrhage, with giving women the opportunity to make an informed decision about having the perineum sutured immediately or waiting for a short period of time in order to regain composure.

The National Institute for Health and Clinical Excellence (NICE) is an independent organisation responsible for providing national guidelines on the promotion of good health and the prevention and treatment of ill health. Draft guidelines on intrapartum care (NICE 2006) are currently in the public domain for consultation and are recommending that perineal repair should only be undertaken with adequate, tested analgesia in place. These guidelines, if agreed, would add strength to the requirement to ensure all women who need to have their perineum sutured, have received adequate pain relief before the procedure is started.

Some women in the study by Green et al (1998) complained about the baby being taken away while their perineum was being sutured and there was a lack of information given about the extent of the tear or the number of stitches they had. These experiences are echoed by Janet who felt that being stitched was painful as well as prolonging the time it took for her to cuddle Thomas.

> *"though I got to see him I couldn't really cuddle him. I was like in this position (demonstrates lying flatter on the settee), so Brian (husband) had him, so I was a bit upset about that. But er, er the other thing that was going through my mind was, it was quite painful actually (laughing), to have my legs up in that position for so long. Wasn't anything compared to giving birth to him, but I wanted her to get it over and done with so I was pestering her a little bit saying, 'oh have you finished, can you hurry up?' I kept pestering her, I kept apologising saying I am really sorry but I know I am hurrying you up with this but it is really uncomfortable. So I think because I wasn't really expecting it I was a little bit miffed we couldn't have the whole, you know have him on my tummy and have a nice cuddle or anything like that really. Because I was so (laughing), legs a kimbo, you know. Lying flat, you know."*

Janet didn't like the time it took to have her perineum sutured and wanted it to be over and done with. It was an experience she hadn't expected to be subjected to, having imagined that she would be able to cuddle her baby as soon as she had given birth. Janet expressed disappointment at the whole process and was not the experience of normality that she was expecting.

The position women are placed in for suturing perineal trauma is usually lithotomy, where women are lying on their backs and their legs are placed in stirrups. This affords a clear view of the area to carry out the procedure (Downe 2003). However, according

to Tunnadine (1992) and Walton (1994) using the lithotomy position can cause distress and humiliation after the excitement of giving birth, resulting in short or long-term problems for women. Tunnadine (1992) recalls women feeling helpless as they described being 'slung up' or feeling like a 'beetle on its back'. The act of restraining women's legs in stirrups during suturing of their perineum may also bring back locked in memories of sexual abuse making them feel helpless and out of control (Walton 1994). Crompton (1996) supports this understanding in her literature review of post-traumatic stress disorder (PTSD) and childbirth. She argues that women and children who have been victims of sexual assault or child sexual abuse may be reminded of their abuse by events occurring later during childbirth. The review was written to increase midwives understanding of the impact of trauma by describing the symptoms and diagnosis of PTSD and what the experience is like for the sufferer. Crompton cites from the American Psychiatric Association (1980), that PTSD is an environmentally determined psychiatric disorder that has been recognised to exist without physical or psychological predisposition. Therefore events similar to war, major environmental disaster or personal trauma, such as abuse, may trigger the disorder. Women who come to childbirth with a previous history of trauma, then further pain, unresolved helplessness and perceptions of loss of control can be influential in their reaction to interventions. Interventions such as painful vaginal examinations, immobilisation in lithotomy stirrups, episiotomy or suturing the perineum without adequate analgesia could all be a cause of distress. Having the procedure carried out by a male obstetrician should also be taken into account as this could trigger memories for the woman of previous domination by her abuser. These interventions may then be the catalyst for PTSD.

The midwife may not know a woman's previous experience of domestic or sexual abuse unless it has been voluntarily disclosed. It is known that in England and Wales 20 percent of women say they have been physically assaulted by a partner at some point (Department of Health 2005). It is also known that many children under the age of 16 years are sexually abused each year in the UK. Midwives are more than likely therefore to come into contact with women who have been, or still are, being subjected to physical and / or sexual abuse. Midwives may suspect abuse if there is something different or unusual from the responses women give, or indicated by their non-verbal

cues. For example becoming distressed at the knowledge of knowing they are about to have a vaginal examination. Midwives must be sensitive to all women's needs especially at the time of stitching any perineal trauma. Most perineal repair can be satisfactorily performed with women lying comfortably in bed with their legs supported on either side by attendants if necessary (Nisbet and Rouse 1992; Kettle 2004), so long as there is a clear view of the perineal area that is to be stitched. Following the birth of her first baby Anne's perineum was sutured with her legs placed in the lithotomy position. The suturing of Anne's perineum following the birth of her second baby was done without using the lithotomy position and comments it was a better experience this time round:

> *"The thought of this (having stitches) brought back memories of the 3 stitches that I had with my 3 year old daughter. However to my delight the midwife decided to give me the stitches there and then – it was over in minutes, no stirrups and I did not feel a thing – much better."*

Georgina also reflected on her previous experience of her perineum being stitched remarking on the difference not having stitches this time made:

> *"Mm, because I knew I did not have to go through the extra pain of the stitching and the waiting to be stitched, which was you know, it was really nice not to have that this time. So it was something I did not have to go through, that's how I felt. So that was a definite benefit."*

It is clear from the descriptions offered by the women in my study that negative experiences still occur when the perineum is being stitched, despite there being evidence for many years identifying how unpleasant it can be. There are implications for practices related to this about why, even though there is evidence available to support a change in practice, women still have traumatic experiences having their perineum sutured.

A reason why evidence has been slow to change practice is put forward by Taylor (1999) who argues that part of the reason practice does not change is that student midwives find it difficult to challenge the status quo. She believes students learn about evidence-base practice in the classroom environment but often see bad practice in the

clinical area. Because of the hierarchy that exists within many maternity units between midwives and obstetricians, especially where there is a strong emphasis on a medical model of care, then challenging the practice of 'your superior' is not easy. This hierarchy also exists between midwives where the 'sister' is seen as a person who is able to dictate practice and should be followed. A misunderstanding within the midwifery profession is that each midwife is accountable for their own actions and omissions, regardless of the advice or directions from another registrant (Nursing and Midwifery Council 2004b). Anecdotal evidence from talking with student midwives while working as a midwife teacher, would suggest that students who do challenge the status quo are often labelled as being awkward or difficult and because of this do not want to jeopardise their practice assessments by continuing to be challenging. Aslam (2000) also suggests that barriers to change include midwives lack of confidence in understanding research evidence as well as the reluctance to change something, which in their view, has always worked well.

Women having their second baby were still able to vividly recall their previous experience of having their perineum stitched, a finding that midwives should reflect on and discuss with women during the postnatal period. The importance of discussing events with women is supported by the findings of the study by Garcia et al (1998). In their national postal survey of a representative sample of women who had given birth in June and July 1995 in England and Wales found that around one in five women who had wished to talk to a member of staff about their birth had not been able to do so. The questionnaire did not go into any detail about the topics women would like to have discussed, but a number of women wrote in the open section at the end of the questionnaire stating that they wished they had been given more information about why events happened they way they did. Sustaining perineal trauma or having an episiotomy are events that women may wish more information about.

Some maternity services have tried to address the problem of women not being clear what had happened during the labour and birth by introducing a listening and information service (Charles and Curtis 1994). Women benefiting from the service included those who had instrumental as well as spontaneous vaginal births. Charles and Curtis suggest that if midwives were to offer this service to all women about the

events that took place during labour and the birth, few women should be in the situation of not knowing what happened during this time. Information may include why an episiotomy was necessary if her baby had become distressed very near to the end of labour. However, Lavender and Walkinshaw (1998) note that with increasing demands on midwifery time women are not always given the opportunity to discuss their labour and birth. They note that women can be discharged from hospital with little knowledge of the events that took place during the labour and birth.

Midwives who were present at the birth are best placed to talk with women about what happened. With first hand knowledge midwives could answer questions directly, and would be less likely to have to defer to someone else for the relevant information. Unfortunately this rarely occurs as identified in the study by Lavender and Walkinshaw (1998) where they noted one of the disappointing findings was that over 90 percent of women did not see the midwife who was present at their birth, during the postnatal period. Their study examined whether postnatal 'debriefing' by midwives could reduce psychological morbidity after childbirth. Using a randomised control trial 120 postnatal women giving birth to their first baby were recruited and allocated by sealed envelopes to receive the debriefing intervention (n=56) or not (n=58). Women randomised to the intervention group participated in an interactive interview in which they spent as much time as necessary discussing their labour, asking questions and exploring their feelings. One of the strengths of this study is that a research midwife, who had no formal training in counselling, conducted the interviews. This meant if the outcome was positive then any midwife without extra training could carry out the debriefing.

Three weeks after the birth a questionnaire was sent to all women in the study to evaluate information they received and to assess their emotional wellbeing. The women in the experimental group were more satisfied with the amount of information they received and were less likely to return home with unanswered questions. There was a high level of morbidity in the control group, which the research team found worrying. However, they acknowledge that the results need to be interpreted with the understanding that the women knew if they were assigned to the intervention or control group, so women may have responded positively in the experimental group to the

midwife, who sat with them and listened and responded to their concerns. Likewise the women in the control group may have wished they had received the intervention and so did not respond so positively. It was also noted that the Hospital Anxiety and Depression Scale used to develop the questionnaire for the postnatal period, had not been validated for the puerperium. Despite this Lavender and Walkinshaw (1998) concluded that the support, counselling, understanding and explanation given to women by midwives in the postnatal period provides benefits to their psychological wellbeing. They recommend that maternity units have a responsibility to develop a service that offers all women the option of attending a session to discuss their labour. As part of the discussions women's experiences of having their perineum sutured could also be explored.

Lavender and Walkinshaw (1998) used the term 'debriefing' in their study, which has a number of interpretations and is a source of controversy with some evidence suggesting that it may cause more harm than good (Small et al 2000). Debriefing is designed to reduce traumatic reactions for individuals following disturbing incidents and is used in midwifery for women who are traumatised after childbirth. A literature review carried out by Collins (2006) to find out what was written about the purpose of debriefing women in the postnatal period identified a range of debriefing type services being offered to women, from midwives facilitating it as part of their normal work to formal psychological debriefing by trained health professionals. This range makes it difficult to compare services as they can vary greatly. Psychological debriefing is common in the military where it is used as a therapeutic intervention to treat soldiers traumatised by battle and undertaken by appropriately trained health professionals. Debriefing in this context may not be the most appropriate means to listen to women in the first instance (Ayes et al 2006), but used when midwives are concerned about the reaction some women may be expressing to their birth experience and see the need to refer such women to experienced counsellors. It is important therefore, that before any service is made available to women, it must be made sure that referral systems are in place for women to see a psychologist or trained counsellor where necessary (Hammett 1997). More appropriate for the majority of women following birth would be midwife-led debriefing where women meet a midwife or midwife-counsellor to go over obstetric events of birth and express their feelings about the birth experience they had.

Debriefing is a fairly new concept in maternity services, but could be argued that midwives ought to be concerned why women need this service and should be seen as an indictment of the care many women receive in the 21st century. Occasionally there may be incidences where it could be appropriate, for instance when an emergency caesarean section has taken place for a very preterm baby that died very soon after birth. Even in this example however, if midwives and obstetricians were compassionate and caring there should not be a need to provide anything extra, over and above the care the women should normally expect to receive. However, for women who have been subjected to uncaring and dismissing health professionals, who then find they need to access a debriefing service because of the trauma they have been subjected to, is unacceptable.

The experience and assessment of perineal pain

Women in my study demonstrated that perineal pain and discomfort was an inevitable and immediate consequence of giving birth and continued to be experienced at various stages during the early postnatal days although reducing in intensity over time. This is similar to the view from Albers et al (1999) who suggest the majority of women having a vaginal birth will experience some degree of perineal pain. Pain is an unavoidable consequence of any tissue trauma and is associated with the initial stages of wound healing (Collier 1996; Strimike et al 1997). The International Association for the Study of Pain (1994) describes pain as an unpleasant sensory and emotional experience associated with actual or potential tissue damage. Perineal pain is defined as any pain occurring in the perineal body (appendix 1, Kettle 1999).

The pain and discomfort women experienced from the perineal trauma were fairly constant during the early postnatal days. Words women used in my study to describe their perineal pain ranged from 'feeling sore' to 'very painful', and as Ruth remarks, was not necessarily expected.

Ruth:
"I did not expect to be so sore on the second day."

Hannah:
"Anyway, day one has been very painful indeed."

MacVane Phipps (1999) suggests women are ill prepared for the experience of pain, and that antenatal education focuses too heavily on pregnancy and labour, resulting in ignorance about both the physical processes of the puerperium and the pain that these processes can cause. It is because of this that MacVane Phipps argues that most women's experiences of the postnatal period are visibly out of tune with the expectations they have developed from professional advisors about what the process will be like. Sarah clearly highlights she was not expecting the degree of perineal pain she was experiencing:

> *"Yeah, yeah you don't think about how much pain you are going to be in afterwards, plus with having to cope with a baby, so that I think was the most difficult thing that I wasn't expecting any of that."*

More information and better preparation regarding perineal pain was Cater's (1984) aim in her study that sought to reduce the amount of pain experienced by women. The sample size of 315 included women who had an episiotomy, a perineal tear or intact perineum and attempted to examine the effect of a 'good level of knowledge of episiotomy' and its relationship to perineal pain. The hypothesis was that mothers who knew about episiotomy and the possibility of pain, report less discomfort than those without this knowledge. The results of this study found it impossible to draw a parallel between knowledge and level of discomfort, since no respondent was able to complete the questionnaire accurately in regard to structures incised at the time of episiotomy, the length of incision or the position on the perineum were an episiotomy is performed. What Cater did establish was that attending antenatal classes was associated with a better knowledge-base than non-attendance, but the women did not experience less discomfort. Therefore information giving alone is not the answer to prepare women for the reality of pain following childbirth.

Studies by Sleep et al (1984) and Sleep and Grant (1987a) identified that perineal pain is not solely confined to those who sustain perineal trauma but is also apparent in women who had intact perinea. Physiological consequences of muscle stretching around the birth canal can result in oedema and bruising which also causes pain (Steene 1998). Debbie, who did not need any stitches, still complained of discomfort:

> *"No stitches needed as there was only a couple of external grazes, but felt very bruised when first sitting down."*

It is important for midwives to recognise and understand that perineal pain is a source of distress and discomfort whether an actual perineal tear is present or not. Women who have sustained slight damage may experience as much pain as women who have sustained a large degree of tissue damage (Wylie 2000). During the first 10 days following the birth of a baby, midwives may be the only health professional to be in daily contact with women, either in hospital or in the home (Nursing and Midwifery Council 2004a). Women are more likely therefore to turn to their midwife to seek understanding about the pain and discomfort they are experiencing, as Fran explains:

> *"Told midwife about the stinging and she said as the swelling goes down more feeling comes back as the swelling can numb the area. Makes sense."*

This chapter has discussed at length the controversial and problematic question of whether knowledge can or cannot help. The above response given by the midwife is a good example of knowledge being shared at a time that was useful to meeting the needs of Fran. It helped to allay the anxiety Fran was expressing.

Pain is a complex process; it is personal and subjective and can only be felt by the sufferer. This is supported by the view from McCaffery (1999) who identifies pain as whatever the experiencing person says it is and exists whenever they say it does. Because of the frequency of perineal pain and discomfort women have following childbirth, an important role for the midwife is to assess the intensity and type of pain being experienced. However, as this section identifies this is not always the case.

Pain is not just a physical experience but multi-dimensional in nature and poorly recognised by health care professional (Hawthorn and Redmond 1998). Although this view from Hawthorn and Redmond primarily relates to care provided by nurses, there is evidence to suggest that this is similar in midwifery (Glazener et al 1995; Brown and Lumley 1998). Physical causes of pain are often focussed on at the expense of understanding the capacity of emotional, spiritual and social factors to influence a person's experience of pain is not always acknowledged. For example, the perineal pain women are experiencing may be overlooked if culturally they have learnt to not complain and whose facial expressions do not reveal the depth of suffering. This may be exacerbated if the midwife providing care comes from a culture where it is normal to show dramatic expression of pain. It would be important for midwives to recognise the degree to which their own cultural biases may influence their assessment of pain.

Assessing pain is only effective if the aim of managing pain is the same for women and midwives. When discussing the differing beliefs about normality in chapter 3, it was noted that many midwives see childbirth as a normal event and that perineal trauma was not an uncommon outcome of birth. With this view of normality perineal pain and discomfort may be considered differently from the wound pain women experience following a caesarean section. Both outcomes have a wound and may affect the women's ability to mobilise or care for her baby, but each are often managed differently when it comes to giving analgesics for pain relief. For example, women following a caesarean section have strong analgesia prescribed by the obstetrician and is administered by the midwife on a regular basis, and lasts for several days. Patient controlled analgesia is also an option in many hospitals where a specially designed infusion pump allows women to self-administer small doses of analgesia until they feel comfortable. The pumps only allow predetermined doses of analgesia to be given within safe limits. The midwife administering prescribed medication or using patient controlled analgesia aims to keep the relief of pain at a constant level rather than waiting for women to ask for analgesics when they begin to notice the pain getting worse. If pain were allowed to progress before more medication was taken then there would be a time lag before further pain relief would take affect. In contrast women with perineal pain often do not have analgesics prescribed on a regular basis such as four hourly. The women are therefore relied on to ask the midwife for pain relief, if the

midwife has not offered it at an appropriate time. Women may not know to ask for pain relief on a regular basis unless the midwife has discussed this with them.

Often women are home within 24 hours of birth and unless they have taken a supply of prescribed medication home they may only have 'over the counter' medicines at home to relive any pain, such as paracetamol 500mg tablets. Usually this is sufficient to maintain an acceptable level of pain relief. Sarah however, explains the dilemma she found herself in after running out of the Voltarol tablets she was prescribed in hospital to take home, for the severe perineal pain she was experiencing:

> *"...although they gave me a week's worth of Voltarol when I left hospital I ran out and said to the midwife I'm not sure I am going to be able to cope without them. She said well see how you get on today and if you can't get on without them, get yourself down to the doctors. And by 3 o'clock that afternoon I was down there saying can I have some more please?"*

Sarah went from taking strong pain killers to suddenly stopping because she had ran out, and because of the this the pain she had been experiencing was no longer being controlled. Unfortunately it meant for Sarah a trip to the doctors, which may have caused more pain by either having to sit in the car for a period of time or having to walk to the surgery. Therefore Sarah's pain management had not been sufficiently considered and restricted what she was able to do.

Saxey (1986) identified discrepancies in pain management when 35 nurses were interviewed about their knowledge and beliefs in relation to postoperative pain and methods of pain relief. It was found that many nurses believed complete pain relief after surgery was not possible and was therefore not part of their nursing aim. Instead analgesics were given to only reduce the amount of pain experienced. The number of participants in this study was small and relates to a different population from childbearing women and because of this direct comparison of results is not appropriate. However it does provide a useful basis from which midwives can reflect and assess their own practice when dealing with pain management.

It is evident from the women in my study that their perineal pain and discomfort was not being managed effectively as Amanda identifies in her diary entry on day 5 when she realised she could take stronger tablets to relieve her pain:

> *"everything has been difficult today it seems – sitting, standing, eating, feeding Rhys. I did find out I could take brufen which has helped."*

The difficulties Amanda was experiencing with the perineal pain she had was preventing her from carrying out a number of daily activities she would normally undertake with ease, such as walking and sitting. A more recent study by Schafheutle et al (2001) found similar results to Saxey (1986). The aim of this study was to identify perceived barriers to effective pain management in nursing practice. A variety of approaches were used to collect data: six nurse interviews and a survey of 180 nurses in 14 UK hospitals, which built upon detailed observations of nurses on surgical wards. The results identified that from an option of four categories, which asked nurses their overall aim of administering analgesics, the majority (n=63.5 percent) chose 'to relieve pain as much as possible'. The other options included 'complete pain relief' (n=33.7 percent), 'relieve enough for the patient to function' (n= 2.2 percent) and 'enough for the patient to tolerate it' (n= 0.6 percent). All nurses stressed that it was not consistently possible to relieve pain completely. This was largely due to being realistic about what was achievable within the constraints that were evident in practice such as, lack of time to question patients appropriately due of staff shortages and workload. A limitation to the study is that the finding were restricted to the same types of wards, vascular and urology and further work would be needed to ascertain whether the results were related to the specialities or are more widely applicable to pain management. A strength however, is that the survey developed from scrutinising nurses working on surgical wards and thus observing real practice in the natural setting.

The study by Saxey (1986) and Schafheutle et al (1997) are set in a different professional arena to midwifery, so direct comparison is not appropriate. But it does raise the possibility that if women and midwives are trying to achieve two different goals, namely complete pain relief versus reduction in pain, then it is understandable women may feel dissatisfied with the treatment of their perineal pain. As perineal pain

was an unexpected outcome of birth and exacerbated by not having the pain completely relieved then it can be understood how the women in my study found returning to normal a challenge.

Dissatisfaction with relieving perineal pain is explored by Salmon (1999) in a study of identifying that women's accounts are not valued as a reliable source of legitimate knowledge by health care professionals. Textbook knowledge and other conventional sources were believed to be more reliable by health professionals, who included midwives, when determining how much pain women should or should not be experiencing. Illich (1976) relates this problem to the dominance of the medical profession over traditional cultures denying the personal meaning that is given to the experience of pain. Illich argues that the medical profession judges which pains are authentic, which pains have a physical base or a psychic base and which are imagined. This approach is a cause for concern as it implies women are unreliable to judge the intensity of pain they are experiencing and that health professionals believe they know best. Health professionals are making a judgement on what they see, which may not match the intensity of the pain that is being experienced.

Indifferent attitudes to perineal pain by midwives have also been documented, especially within the non-medical literature such as those published by organisation like the Association for the Improvement of Maternity Services (AIMS) and the National Childbirth Trust. The Avon Episiotomy Support Group was launched to establish a network of women available to one another for help, advice and a sympathetic ear (Purcell 1994). Part of their aim was to provide the support that women had found lacking from midwives.

One way to try and address the indifference midwives may have to appropriate pain management is by using pain assessment scoring. Assessing type, frequency and severity of pain is a common approach in other areas of health care, especially in assessing postoperative pain. Many attempts have been made to develop assessment tools, which would provide objective data about different dimensions of the pain experienced. The use of such tools would provide a way of documenting the pain being experienced in a meaningful way to enable continuity of care, particularly with

chronic (long term) pain where individuals may come into contact with many different health professionals. By using a pain assessment tool in this way means that individuals need not have to explain their pain and its progress or otherwise at each new meeting.

Midwives would not take the lead in chronic pain management of medical conditions women may have, such as rheumatoid arthritis, as this would remain the responsibility of the multi-disciplinary team already involved. However the principles of using a method to document the pain would have merit in midwifery care, especially as women do not always see the same midwife at each postnatal visit.

The range of interpretation of pain has led to the development of various measurement tools that address different components of pain. The intensity of pain can be assessed in a variety of ways such as Verbal Rating Scales and Visual Analogue Scales (Hawthorn and Redmond 1998). The Verbal Rating Scales are category scales consisting of various words such as 'mild' or 'severe' and are ranked at equal intervals along a line. This is an easy method to administer but Hawthorn and Redmond argue that patients have to put their pain into words, which may not describe exactly the pain they are experiencing. The Visual Analogue Scale consists of a 10cm line with the words such as 'no pain' and the 'worst pain ever' flanked on either side. The line is marked at the point that best describes the intensity of the pain. Again this is easy to administer but difficulties arise when comparing studies using the Visual Analogue Scale, as there is little consistency between the words used as well as the way the line that is drawn (Deschamps et al 1998).

The McGuill Pain Questionnaire is one of a number of questionnaires available combining rating scales, open and closed questions as well as body diagrams for individuals to document the location and distribution of their pain (Hawthorn and Redmond 1998). It is a reliable and valid tool to measure multiple dimensions of pain, can discriminate between different types of pain and able to demonstrate the effect of treatment of pain. Coll et al (2004) undertook a review of the available literature related to critiquing tools for measuring pain. It established that the Visual Analogue Scale was a suitable tool for measuring the intensity of pain after day surgery. The

scale was found to be methodologically sound, conceptually simple, easy to administer and unobtrusive to the patient. Further research to determine if this tool is suitable for use in assessing perineal pain could add to the effectiveness of pain management for women in the postnatal period. Pain is not a normal experience so if it can be managed to the satisfaction of women when it occurs, it could help them return to a sense of normality quicker. As this is not a tool that is regularly used by midwives there are implications for education and training in both the initial preparation programme but also for midwives in employment to be able to use the tool effectively. Implications for the initial preparation of midwives are developed further in chapter 10.

Summary

This chapter has identified those women in my study who gave birth to their first baby and sustained perineal trauma that required stitching, found the procedure painful and sometimes distressing. The experience was different for women having their second or subsequent baby who vividly recalled their previous experience of having their perineum being stitched and were pleasantly surprised if stitches were not necessary this time round. Those women who did require perineal stitches found the experience far less traumatic second time round. This meant the women were able to return to normal more quickly as they did not have the associated symptoms from perineal sutures to cope with.

Women who gave birth to their first baby were ill prepared for the intensity of the perineal pain they experienced. This was exacerbated by the fact that pain relief was often not complete and this was not necessarily the aim of midwives to achieve. Using pain assessment scores would be one way forward to achieve consistency with pain management.

Pain associated with perineal trauma that was sustained when giving birth meant women in my study needed to make adjustments in how they carried out their daily living activities, and is the subject of the next chapter.

CHAPTER 6
ADJUSTING TO THE REALITY

Introduction

This is the third of three related chapters. The consequence for the majority of women birthing their baby vaginally resulted in a perineal tear or episiotomy, with a few women maintaining an intact perineum. Regardless of the degree of trauma all women experienced perineal pain and discomfort. The previous chapter detailed how expectations women had of the outcome of giving birth did not match the reality they experienced in terms of their perineum being sutured and the intensity of perineal pain being felt. This chapter explores the impact perineal pain and discomfort had on the women's ability to carry out their daily living activities and the adjustments they made to cope with the changes.

In order to try and carry on as normal, women in my study used a variety of methods to help relieve the pain they were experiencing. These included bathing or using the shower, taking oral analgesia and using products for local application, such as ice packs, and electrical therapies as recommended by the physiotherapist. This list is similar to those referred to by Sleep and Grant (1988a) during their telephone survey of 50 randomly selected maternity units in England. They found first line management for perineal pain was usually oral analgesia (78 percent). Of the 78 percent using oral analgesics 98 percent used paracetamol for mild to moderate pain. Ice packs were the most popular topical treatment. More recently Harris (1992) surveyed 100 members of midwifery and medical staff to ascertain their treatment of perineal pain. Comparable results were found and interestingly both studies identified midwives and doctors lacked an evidence-base to support their practice of pain management. Sleep (1991) reviewed treatments for perineal pain and concluded no trials produced evidence that was persuasive about overall benefits in the area of reducing pain or improving healing.

Women and their management of perineal pain

In my study, women referred to using the bath or shower as a way of relieving pain rather than for hygiene purposes.

> Fran:
> *"Just bathing in warm water really. And I found just soothed it (perineal pain)."*

Georgina preferred to shower:

> *"It helps a lot to put the shower on the area (perineum) and pat dry."*

This method however, did not suit everyone such as Clare, who found the heat of the water difficult to cope with and opted to wash instead of bath.

> *"I had a wash instead of a bath as it stings with the heat of the water and putting with luke-warm water and a flannel is better as it does not sting as much as the water is cool and soothes it."*

The difference in temperature of the water was significant for the women. One small trial compared the effects of perineal pain when sitting in either warm or cold sitz baths (Rambler and Roberts 1986). Sitz baths are a type of bath in which only the pelvis and abdominal areas are placed in water, with the upper body, arms, legs and feet are out of the water. The findings of the trial established that cold sitz baths were more effective in relieving discomfort especially immediately following birth. However, it is noted that 119 women out of the 159 approached to enter the trial refused to participate; the main reason being the reluctance to be immersed in cold water. This trial identifies that although there may be some benefit to sitting in cold water to relieve discomfort in the early postnatal period, the treatment must be acceptable to the women who are using it. It is evident from this trial that immersion in cold water was not an option many women would choose. In contrast women are not averse to using cold therapy if locally applied to the perineum and ice packs are a treatment often suggested by midwives for perineal discomfort. Hatt (1991) argues that an item such as a pack of

frozen peas is always available, especially postnatally, when women are in their own homes. This is demonstrated by Sarah's comment:

"I even had a pack of frozen peas between my legs."

The application of cold compresses has been in use for centuries as a form of localised treatment and these have become an accepted method of treatment for acute injuries (Steen and Cooper 1998). They appear to give symptomatic relief by numbing the tissues but concerns have been raised that cold therapy can delay wound healing through excessive cooling and accompanying vasoconstriction of the injured tissue (Walker 1990; Grundy 1997). Although ice application will effectively lower skin temperature, it is noted by Steen et al (2006) in their literature review to assess the evidence for using localised cooling methods to alleviate the effect of perineal trauma, that due to the low conductivity of the underlying subcutaneous fat this will prevent cooling of deeper tissue.

Ice burns are another concern when using icepacks which can occur as a result of contact with the skin and surrounding tissues, especially if the ice is placed next to the skin without being properly covered or left too long in position. In view of these concerns, Steene and Cooper (1998) undertook an in-depth literature review using articles from CINHAL, MEDLINE, MIRIAD and the Cochrane Collaboration Pregnancy and Childbirth Database. The Cochrane database contains systematic reviews identifying an intervention for a specific disease or other problem and determines whether or not this intervention works. Systematic reviews adhere to a strict design in order to make them more comprehensive, thus minimising the chance of bias and ensuring their reliability (Cochrane Library 2006). Searches were carried out on the literature published between 1960 and 1997. Steene and Cooper concluded that there is no clear evidence to support the suggestion that when controlled cold therapy is applied to the traumatised perineum this will result in delay in wound healing. The recommendation was made to continue this treatment until clear evidence is produced to the contrary. Despite the frequent use of cold therapy there is difficulty associated with accurate positioning especially on an area such as the perineum, although there are

new products on the market, which try to address this (Steen and Cooper 1998; Steen 1999).

Some remedies the women tried in combination with water had the effect of providing pain relief but were also used to promote wound healing. These were not necessarily supported by research evidence, but were still recommended by family and friends. Taking advice from family and friends was previously considered in chapter 4. Fran and Janet were both recommended to add salt to the bath water.

> Fran:
> *"my mum kept saying, oh use salt water but everybody else said, oh no doesn't make any difference."*

> Janet:
> *"Saw a friend who recommended salt baths when home..."*

Salt is one of the oldest remedies to sooth pain and promote healing although its precise mode of action is unclear (Watson 1984) as well at the quantity of salt required to have a therapeutic effect. Sleep and Grant (1988b) undertook a randomised controlled trial to test the hypothesis that salt, Savlon concentrate or both added to the bath water would reduce the frequency of perineal pain, improve wound healing when assessed ten days after delivery, and provide symptomatic relief during these ten days. The findings of the trial are strengthened due to the inclusion of a group of randomised women who used no additives to the bath water. An acknowledged weakness to the trial was that observation was uncontrolled, that is the women knew which method they were using which could have introduced a bias and influenced how they reported the results. There is also no way of knowing either whether the women would have gained relief if they had not bathed at all or had used showers rather than baths. The outcome of the trial was 93 percent of women who were questioned on the tenth day following vaginal delivery reported that bathing had relieved their discomfort. The prevalence and pattern of perineal discomfort on the tenth day of the postnatal period was similar in all the groups. Wound healing assessed by the community midwife on the tenth day was also similar in the groups. This meant that the addition of any of the substances was no better than using water alone. It is noted that women in my study found soaking in the

bath of great comfort so if they wished to add salt as in Janet's case, it is known from the study by Sleep and Grant that this would do no harm.

Sarah added lavender oil to the bath water on the advice of her midwife having been told her perineum was gaping and leaking fluid and that as lavender oil has antibacterial properties, it would help with the healing:

> *"Then she said (the midwife) lavender oil is antibacterial as well as healing, I thought cricky if it is beginning to leak stuff it could be getting infected or something so I sent my husband down to get the lavender oil. And from that point on I really was having baths about three times a day."*

Dale and Cornwall (1994) conducted a randomised control trial involving 635 women, comparing pure lavender oil, synthetic lavender oil or an inert oil added to the bath water on each of the first 10 days postpartum. Daily discomfort scores were assessed using a visual analogue scale, as described in chapter 5 but no significant differences between the groups were found. Despite the results women using the oil found it pleasant to use, with no unpleasant side effects. Bick et al (2002) recommend that further trials be required to assess the safety and benefits of alternative remedies before they can be recommended as effective for pain relief. However, similar to the study by Sleep and Grant (1988b) as there were no identified side effects women may still feel benefit in using the oil. Sarah used the lavender oil three times a day and felt that it helped a lot although there was no evidence to suggest it was the lavender oil that had made the difference. It is important that midwives give advice on the best available evidence, but when providing information should also respect women's individual experiences of pain and preferences for its relief.

Apart from using water to help relieve pain and promote healing, some women like Hannah and Janet describe taking oral analgesia such as paracetamol to help relieve their perineal pain:

Hannah:
"I have taken sort of like paracetamol along the way but nothing, nothing really more than that."

Janet:
"In the evening I would have paracetamol in the hospital mainly."

Dewan et al (1993) sought to determine the most effective choice of oral pain relief out of two that were frequently used in the maternity unit she worked in, paracetamol and mefanic acid (Ponstan, a non-steroidal, anti-inflammatory drug). One hundred and ninety eight women were questioned about any pain they were experiencing on the first, second and fourth day post-birth. They were asked to rate it on a four-point scale (none, mild, moderate or severe), as experienced 12 hours before the interview. The use of analgesia was recorded and women estimated its effectiveness also on a four-point scale (none, slight, moderate or good relief of pain). Perineal pain was frequently reported and mefanic acid gave a better outcome for pain relief. Only 17 percent of women reported 'good pain relief' when using paracetamol compared to 58 percent who used mefanic acid. Therefore they recommended that mefanic acid should be used more often as first line management.

Midwives need to consider that women may not wish to take analgesics for a variety of reasons, especially as in many cases components of the drug may be transmitted to the baby through the breast milk with a detrimental effect on the baby. This is an important consideration for pain management during the postnatal period as there is medication available that can be used with minimal or no affect to the baby (Banister 2004). Treatment for severe pain has been more problematic as drugs can be excreted in breast milk. There are risks of maternal side-effects such as gastric upset or dependency, and issues of cost. Harris (1992) notes that women with episiotomies or those having suffered severe tissue trauma were not offered more potent oral combinations or intramuscular injections.

The effectiveness of pain relief has been examined in a Cochrane review (Hedayati et al 2004). Three trials were identified, with two contributing data to this review of the use of non-steroidal anti-inflammatory drugs (NSAIDs) administered as rectal suppositories immediately after perineal suturing and in some cases again later. Women were less likely to report pain within 24 hours of giving birth following administration of NSAIDs, such as Voltarol 100mg administered rectally 18 hourly,

compared to a placebo, and needed less additional pain relief within the first 48 hours postpartum.

A further method to relieve perineal pain and discomfort that Sarah used was pulsed electromagnetic energy therapy (mega pulse), where interrupted, high intensity energy waves are locally applied to the perineum. Electrical therapies are common treatments used by physiotherapists on the postnatal wards for women with severe perineal pain. Sarah took the advice of the midwives to have a course of mega pulse but was sceptical about its effects.

> Sarah:
> *"I couldn't tell you if it did or not because I never felt it, I never (pause), I was always a bit sceptical as to whether or not it would work because it did not seem to be doing anything...but all the midwives who have come have all said it is wonderful and that you should have it if you get offered it."*

Being sceptical may have been appropriate for Sarah when taking into account the findings from the work of Grant et al (1989), although she had nothing to compare this line of treatment with. Grant et al (1989) evaluated the use of ultrasound and pulsed electromagnetic therapies with 414 women who had moderate or severe perineal trauma. Each mode of treatment was compared in a randomised, double blind controlled design. Therapy was started within 24 hours after delivery, a maximum of three treatments being given during a 36-hour period. The participants in the study assessed their pain both before and after each treatment, at the end of 10 days and at three months postpartum. Overall, more than 90 percent of women felt the treatment helped their perineal pain. Other than more pain being reported at ten days in the group that received active pulsed energy electromagnetic therapy, there was no clear difference between the groups. Neither the ultrasound nor pulsed electromagnetic therapy had an effect of perineal bruising or haemorrhoids. Using a randomised, double blind trials as well as the large numbers of women recruited are two features that provide confidence in the findings. The randomised, double blind trial meant that the operators did not know of they were using the treatment or placebo and the women did not know if it was the intervention or placebo they were receiving. Sleep (1991) following her review of five randomised controlled trials related to perineal care, which

included the study by Grant et al, stressed further controlled trials were needed to assess different machine settings and length of treatment for both the use of ultrasound and pulsed electromagnetic energy therapies.

Similar results were recognised from Hay-Smith (1998) in her more recent review of the literature on therapeutic ultrasound for postpartum perineal pain and dyspareunia for the Cochrane systematic review. Four trials of therapeutic ultrasound involving 659 women were reviewed, and identified there was not enough evidence to evaluate the use of ultrasound in treating perineal pain or dyspareunia or both following childbirth. There is some evidence from the studies that may be beneficial, such as women treated with active ultrasound for acute perineal pain were more likely to report improvement in pain with treatment, but no other outcome reached significance. Hay-Smith concluded that there was not enough good quality evidence to evaluate adequately the effects of ultrasound in treating perineal pain and that more research is needed.

Despite the upheaval and organisation that was needed for Sarah to attend the hospital, she went ahead with it. Sarah complied with the advice from the midwife even when the evidence is debatable.

"I have done everything anybody tells me. Like the heat treatment."

This supports the findings of research written up by Bluff and Holloway (1994), which explored women's experience of labour and birth. The research demonstrated that women trust midwives because midwives are seen as experts who 'know best'. Data was collected using in-depth unstructured interviews from 11 women who had undergone normal labour and was analysed using the constant comparative method of reduction of codes to categories. Although the sample size was small it demonstrated that women trusted midwives who cared for them in labour. By trusting the midwife, the women would place themselves in the hands of the professionals giving them the authority to make decisions about procedures, drugs and types of care. They also noted that despite the women trusting the midwife who 'knows best' the midwife did not always practice from a sound evidence-base. It is apparent that this is still evident in some of the findings in my study (see chapter 10).

Not all women found the perineal pain worse than expected and women who had had a baby before commented that the pain this time was an improvement from their previous experience, as Fran describes:

> *"I can't help thinking how much easier this one was comparing to the two with forceps which were very painful to move and sit on."*

Coping with the body

Pain and discomfort directly related to the perineal area was not the only pain women experienced and were unprepared for. Carrying out body functions and daily activities also caused the perineal area to become painful or increased the severity of pain already being experienced. The experiences interrupted the ability for women in my study to carry out daily activities without being constantly reminded of the pain they were in. Anne, for example found if uncomfortable to kneel and change her baby's nappy:

Anne:

> *"When I'm on the floor changing Charlotte's nappy I didn't find it easy getting up again - I ache in this position – kneeling."*

In the study by Glazener et al (1995) the painful perineum was included in a list of postnatal health problems that affected women up to 18 months after the birth. The study surveyed 1249 women who were randomly selected at discharge from hospital, and asked about their postnatal experience in hospital. They were followed up again at eight weeks and 12 to 18 months. The findings identified that some of the most common health issues reported included, constipation, piles and difficulty with passing urine. The large number of women recruited to the study means that the findings are more likely to reflect the views of many women in the postnatal period and can be usefully applied across a population of women in the postnatal period.

Brown and Lumley (1998) two researchers from Australia conducted a similar survey to that of Glazener et al (1995). Brown and Lumley wanted to describe the prevalence

of maternal physical and emotional health problems six to seven months after birth. Data were collected using a postal survey of all women who gave birth in a two-week period in 1993 in Victoria, Australia. Women excluded from the study were those who had a stillbirth or neonatal death. The questionnaire was distributed to women six to seven months after childbirth and the response rate was 62.5 percent (n = 1336). The respondents were largely representative in terms of important obstetric characteristics such as the number of previous live births, birth weight of the babies in the current pregnancy and method of birth. There were a few groups of women who were underrepresented: women born from overseas and women younger than 25 years of age, which means that the results cannot be representative of all women. A major strength of the study is that is draws on a large sample of women who self-reported health problems rather than relying on information from health professionals who are known to under-report them (Glazener et al 1995). Although the women in this study were from outside the UK and any direct comparison to women within the UK needs to be treated with caution, the results from the study by Brown and Lumley were similar to those by Glazener et al (1995) and included such health issues as perineal pain, haemorrhoids and sexual problems, all of which were also common to the women in my study. In these instances women used different strategies to cope with the pain in order to try and carry on as normal.

Passing urine was painful and often referred to as a 'stinging' pain. For the women having their first baby this was a new sensation and out of the ordinary.

> Hannah:
> *"I have also been for my first wee and was horrified by the stinging unpleasantness of it all."*

For Anne and Clare this was not a new experience and from previous memories both were worried about passing urine this time.

> Anne:
> *"Worried that going for a wee would still sting and be uncomfortable."*

> Clare:
> *"I was putting off going to the toilet as I knew it was going to sting."*

There is little research available about how best to manage the stinging caused by the flow of slightly acid urine (Rankin 2005) passing over cuts and abrasions around the skin of the perineum and vulva. Any means by which the acidity is diluted would help to reduce the affect. Clare was able to cope initially by passing urine in the bath:

> *"I left it (passing urine) 'till I had a bath...Doing it in the bath doesn't hurt so much as doing it on the toilet."*

Urinary stress incontinence was also a symptom that women had not expected.

> Amanda:
> *"I can pee but there is no control – I just sit on the loo and away it comes which is worrying."*

In order to reduce the likelihood of urinary stress incontinence midwives encourage women to do their pelvic floor exercises in the postnatal period (Bick et al 2002). Logan (2001) defines the symptoms of stress incontinence as leakage of urine on sneezing, coughing, laughing and exertion caused by weakness of the pelvic floor muscles. Childbirth is often cited as the primary cause of urinary incontinence as a result of damage to the pelvic floor following vaginal delivery (Allen et al 1990; Snooks et al 1990). A healthy pelvic floor not only helps to maintain the pelvic organs in the correct position, but it also plays a part in the sphincter control of the bladder and rectum (appendix 1, Laycock 1997; Parsons 1998). It is generally suggested that women should be encouraged to perform pelvic floor exercises almost immediately after the birth (Willis 1997), which Debbie did. Debbie's persistence was as a result of her previous birth experience and the wish to get into a routine quickly.

> Debbie:
> *"Maybe I have made greater effort this time with my pelvic floor exercises because I want to get my new routine settled without having to constantly be dashing to the loo."*

Debbie also clarifies that doing her pelvic floor exercises was a means to help her return to normal by regaining strong muscle control:

"I have still got a lot of work to do with my exercises to return to full strength to all the muscles that were stretched so much."

Conversely, Amanda having her first baby chose initially not to do any pelvic floor exercises believing they would make her perineum more swollen.

"I don't do any pelvic floor exercises in case they make me more swollen."

However, the midwife explained to Amanda that pelvic floor exercises speed up healing by increasing the circulation to that area, which is supported by evidence from Scowen (1996). Pelvic floor exercises in cases of perineal trauma improve the blood supply to the perineum, accelerating the healing process.

Sleep and Grant (1987b) raised the question of the value and content of pelvic floor exercise programmes. They compared the postnatal exercise programme currently in operation in a maternity unit in England with a scheme, which reinforced the initial instructions given in the immediate postnatal programme. This study sought to determine if a more intensive programme would reduce the incidence of urinary incontinence three months after delivery. The reinforced programme included additional teaching sessions, positive encouragement by community midwives and attempts to enhance motivation by personal contact and use of an exercise diary for a month. The study did not find a reduction in urinary incontinence in the reinforced programme group, there being no statistical difference between the two groups. This raised questions for the researchers about the value and content of the exercise programmes currently offered to women around the time of childbirth. What was observed however was a reduction in reported perineal pain in the reinforced programme group. Midwives could therefore use this as another treatment for reducing perineal pain.

In contrast, Bick and MacArthur (1995) reported that the long-term effects of pregnancy and childbirth on women's health suggested that women were not receiving the information they require during pregnancy and postnatally to allow them to take control of the problem of urinary incontinence. Logan (2001) argues that health

professionals who come into regular contact with women during and after pregnancy do not appear well informed about the benefits of pelvic floor exercises and how to teach them. Although most midwives rated their knowledge on anatomy of the pelvic floor muscles and obstetric risk factors that cause incontinence, as 'middle of the road', they generally did not feel confident in teaching them. It was also noted that a significant number of midwives (26 percent in her study) delivered inappropriate and possibly harmful advice. Although there is no agreed national standard to which instructors should work to, the Association of Chartered Physiotherapists in Women's Health provide guidance (Department of Health 2000) and would be important for midwives to be cognisant of the correct method when teaching pelvic floor exercises.

Urinary symptoms was only one of a number of problems that women found themselves having to cope with as a consequence of having birthed their baby vaginally with the resulting stretching and bruising of the perineum, or sustaining perineal trauma. When women referred to having their bowels open this provoked much stronger language than passing urine, and the fear and anxiety was more intense as Amanda and Sarah vividly recall:

Sarah:
"Oh gosh, going to the toilet that's awful... I was so scared. I was sat on the toilet thinking, gosh everything is just going to burst open, I am going to bleed everywhere and it is going to be awful".

Amanda:
" Also I know I need to have my bowels open and feel as though I want to but I cannot get through the fear that if I push the stitches will split so I keep putting it off even though I know it will make matters worse".

Amanda's fear of splitting her stitches is not unusual and Marchant (2003b) recommends women should be reassured about the effect of a bowel movement on the area that has been sutured, as many women may be unnecessarily anxious about the possibility of tearing their stitches.

Constipation was a symptom that women worried about. Some women were anxious not to become constipated because of the increased pain this may cause when having

their bowels open. Bick et al (2002) acknowledge that during the postpartum period women may experience constipation following lack of dietary intake during labour or because of pain from perineal trauma. Attempts were made by the women to alter their normal diet and fluid intake to try and prevent any problems with constipation.

Amanda:
"*I am trying to eat lots of fibre and drink plenty so everything will happen in time I hope!!.*"

Georgina:
"Drinking pure juice to soften any motion as not to strain when I go."

There is limited research into the most effective treatment of constipation and most conservative management of postpartum constipation is based on current clinical practice (Bick et al 2002). Tramonte et al (1997) undertook a systematic review of general population trials to evaluate whether laxatives and fibre therapy, for a minimum of one week, improved symptoms in adults who had experienced constipation for at least two weeks. A total of 36 trials were compared involving 1,815 subjects benefiting the generalisability of the findings. Difficulties with the review included varying criteria identified in the studies for chronic constipation and the duration of the study periods being limited. Also the majority of participants were over 65 years of age and 70 percent were women. The findings revealed that both fibre and laxatives moderately reduced the frequency of constipation, but could not determine if fibre or laxatives were superior. They recommended that laxatives should only be given when dietary and fibre intervention had failed. The age group that dominated the study by Tramonte et al was over 65 years and there were acknowledged problems with comparing trials due to the lack of consensus for a definition of chronic constipation. Despite the difference of age group, the study is one that midwives should have knowledge of when discussing with women the information they require in order to make an informed choice about treatment for constipation.

Midwives, following a medical model of care often resort to giving laxatives such as Senna, to women if they have not had their bowels open within 72 hours. As a student midwife I remember being taught to ask the women on 'day three' if they have had

their bowels open, and if not to give them a laxative, and then tick the box in the woman's records to show the question had been asked. This did not take into account whether women had been starved for the period of their labour, which could be up to 18 hours, what the normal bowel habit for them was, and indeed if they had given themselves time to go to the toilet, despite the overwhelming demands a baby makes of them. Despite the increased fluid and fibre intake for Amanda, she did resort to asking the midwife for a laxative, which resulted in 'great success'.

As well as having to cope with pain when passing urine and being constipated, the women in my study also had problems sitting down, which was uncomfortable, if not painful. Hannah and Janet highlight this.

Hannah:
"Can't sit down flat on anything including the bed as it is very painful."

Janet:
"you would have to sort of position yourself quite carefully before you sat down for diner."

To cope with this, women consciously made decisions about how and where to sit, as well as preferring not to sit at all but to stand or lie down, a point noted by Heffline (1990) who suggest that positioning is an important coping behaviour. Abraham et al (1990) undertook a prospective study examining the time it took for 93 women to stop feeling discomfort in their perineal area after the birth of their first baby. Data was collected through the women's maternity notes as well as interview. It was noted that women used a variety of ways to relieve their perineal discomfort and pain in the early postnatal period. These included sitting down slowly and carefully or differently such as on one buttock, or use a cushion.

Hannah::
"...so long as I sat in the right way and didn't get out too straight as well."

Madjar (1997) likens this to the effort required when climbing a steep hill. She suggests when everything is working smoothly and without effort, the body is not normally something one is aware of. It is only when effort is required, such as

climbing a steep hill, there is an awareness of all that is involved in the complexity of movement. Similarly the women in my study became acutely aware of the muscles and actions involved in sitting and walking. Madjar refers to the unawareness of body functions as 'the absent body'. Pain has the capacity to raise awareness of the body, making the effort involved in the usually taken-for-granted activities noticeable. The pain caused by sitting often led to eating being difficult to manage. The awkwardness of trying to sit and eat meant women were thoughtful about what they sat on, as Amanda and Hannah demonstrate.

> Amanda:
> *"the biggest problem is eating, I am trying to sit at the table on a dining chair with a pillow but it is very painful."*

> Hannah:
> *"I still have a problem with flat wooden chairs. I sat to the dining table today had to put a cushion on the chair to sit there for any period of time."*

Sitting down also affected the enjoyment of breastfeeding where is sometimes turned into an arduous task wanting it to be finished with as soon as possible. Sarah explains the problems she encountered with this experience:

> *"Feeding was, is incredibly painful, probably the first week I would say because although I can do it lying down, and I was doing it lying down in bed, there are situations where, you know he was getting such bad wind as well and still does that I needed to try and feed him in more of a sitting position, him in a sitting position so (um) realistically I was just sitting here with pain, hoping that he would hurry up (laughs). I think that was all that I was doing... I was just hoping he would finish as quickly as possible really. Yes feeding was probably the one thing that was the most painful because you are restricted to how much you can move."*

The benefits of breastfeeding are well documented (Inch 2000; Royal College of Midwives 2002) but if women are in pain while trying to feed their baby they may give up sooner than they wish. Giving up breastfeeding early could leave women feeling guilty.

A number of women also talked about how difficult it was to walk. As a result the women described needing to take care and limit their movements.

Brenda:
"...just takes a little more time, shuffling a little when I walk."

Amanda:
"I remember walking up and down the ward thinking, oh God I really, oh this is, I was walking literally like I had a brick between my legs.

This difficulty with walking meant that the women would plan their movements so they wouldn't have to walk too far in the early days. It also had an impact on looking after the baby, often restricting the care they were able to provide. The following powerful description from Hannah's first entry in her diary illustrates this:

> *"I keep trying to turn over onto my side but can't as my birth canal and actually entire abdomen are very painful have been entirely unable to look after the baby since he was born...there is nothing I can do about it as I cannot move from the bed."*

How women cope with the changes in their body following childbirth is similar to the findings of Griffiths and Jordan (1998) in their study. Although their study examines a generally different experience that of lower limb trauma, in some aspects there are similarities: notably an unexpected 'blow' to the body and a desire to overcome this. They found functional goals such as achieving mobility were seen as part of the process in returning to normal for patients on an orthopaedic ward. The study used diaries and interviews to explore nine patients' experiences of hospitalisation during their recovery from lower limb trauma. The analysis identified that the patients had an overwhelming desire to return to normal. The study by Griffiths and Jordan and the findings of my study suggest that more research and clinical attention needs to be paid to this whole area of normality and its significance to people.

Feeling tired was a problem acknowledged by a number of women in the study and was partly due to demands a newborn baby makes over a 24 hour period, but also caused by the effects of perineal pain and discomfort. Both these problems resulted in Sarah feeling very tired and resenting having to get up in the night to care for James:

"I think sleepless nights would have been easier to deal with if I wasn't in so much pain. It's the one thing I said to my husband it a shame that I have to got to be in the pain and I have to get up and feed him, that doesn't seem quite evenly balanced to me (laughs). You know, can't I just be in the pain and you feed him? Tiredness was making the pain worse I think because each time I heard him crying in the night, I thought, because it meant I had to get up and get into a semi-sitting position which meant more pain and although I have never struggled to get back to sleep, which I am sure I never will, there will always be the time, but (um) I think anybody who is getting enough rest and sleep can deal with a certain amount of pain, but when it is ongoing like that and you are having night after night of broken sleep I think the pain just gets to you more, I think. It certainly did me."

Being tired in Sarah's case made it more difficult for her to manage the perineal pain she was having. This is a further example of the importance of making sure women are receiving the appropriate pain management in order to be able to function at a reasonably normal level. Glazener et al (1995) identified up to two thirds of the women reported tiredness in the postnatal period, and was unrelated to parity or type of delivery. Larkin and Butler (2000) also describe deprivation of sleep and rest following childbirth and that the resulting extreme tiredness affects women's ability to function within their daily life activities. Taylor et al (2001) explain sleep deprivation as being a decrease in the amount, consistency and quality of sleep. Amanda highlights her experiences of lack of sleep:

"..it was nice to feel physically more normal. But that is like a big buzz you get that lasts for a little while, then all the tiredness and looking after the baby kicks in"

Hart et al (1990) suggest management of tiredness should be based on individuals being able to influence their own health. McVeigh (1997) argues that women should be taught during the antenatal period certain strategies, which may reduce the likelihood of tiredness postnatally, including the recruitment of helpful support. Amanda accepted help from her family so she could go and rest:

"all this has led me getting very tired and tearful and luckily my husband and sister sent me to bed and settled the baby whilst I slept."

In Clare's case it was her husband who helped:

"I gave Laura her last bottle at 12.30 am and woke up at 6.30 am and Peter gave her a bottle so I had a very long lay in and feel better for it."

Further strategies could include advising women to change behaviour to overcome or minimise the effects of fatigue, for example taking a rest after feeding the baby. Several short periods of rest are thought to be more beneficial than one long period, which is probably more realistic for postnatal women. However this was not the strategy that Hannah used as the following example identifies:

"it really annoys me that there is stuff everywhere and all the washable nappies, so getting all that sorted out, but now I get up in the morning and (pause), it is really quite straight forward now. He doesn't sleep at the same time every day, but as soon as he sleeps I know I can get everything done in 15 minutes now."

Getting into a routine for sleeping was important for Georgina:

"...a routine of feeding in the night and knowing how long I've got to sleep, I suppose is quite nice. Getting a nice chunk of sleep."

Bick et al (2002) suggests there little evidence for management of fatigue in the postnatal period and tends to draw on qualitative studies of fatigued patients with serious medical illness. Glazener et al (1995) identify sleep as a specific maternal morbidity. It was also the condition that women were least likely to be treated for after eight weeks and when combined with Sarah's example, if pain is not managed alongside tiredness then the problems are exacerbated. Larkin and Butler (2000) do relate some of the issues of fatigue to pain, but is offered in the broadest terms including backache, breast engorgement or uterine pain for example. All of which the women in my study felt a need to describe, but is not directly related to the perineum.

McQueen and Mander (2003) provide an analysis of a selective review of the literature on tiredness and fatigue in health and illness as applied to the experience of the new

mother in the postnatal period. They suggest that on the basis of the analysis childbirth education should be extended to foster more realistic expectations and more effective coping skills to facilitate women's adjustments to motherhood. The possibility of midwives educating mothers about the need to access, recruit and delegate some household activities to willing helpers is addressed. They propose that midwives can help women to have more realistic expectations about life after birth, by providing advice and legitimating the need for support and the use of coping mechanisms to assist the transitions to motherhood. Brenda, in her comments appears to have thought this strategy through:

> *"I've got a lot of support from my family - they've been doing all the washing and ironing for me, and mum has been doing lunch for me, which is a great help."*

Perla (2002) studied the concerns of women during the postnatal period and identified that satisfying basic needs were a pre-requisite to being able to attend to higher level needs in the context of self-care. Critically, the paper does not provide detail of the methods used to obtain the information or how the data was analysed. It is also set in a medical dominated culture where patient compliance is perceived as the 'norm'. However it does provide a useful insight into the importance of communication in understanding the degree of perineal pain women are experiencing and the need for women to control the pain in order to move towards self-care.

Despite the pain and discomfort some women were experiencing there were times when other priorities refocused their concentration away from the perineum. Amanda and Janet had concerns about their baby. Amanda needed to stay overnight in hospital with Rhys and Janet had been told before the birth that Thomas had an irregular heartbeat that would be investigated after the birth. As Amanda and Janet describe, sometimes their worries about the baby made them forget about the perineal pain they were feeling.

> Amanda:
> *"Not really thought about myself as been at hospital all day and obviously very worried about Rhys who is now home and sleepy but ok."*

Janet:
"...there were other things that were more important. When we were in hospital I was more concerned about him, his ECG. When we came out of hospital we had the whole issue of the breastfeeding and he wasn't latching on, he was just constantly, he wasn't in a pattern of feeding, for well, for 10 days so that was obviously distressing, we weren't sleeping, so probably my stitches were not top priority for me I think."

The distractions that Amanda and Janet identified raise the question about how women, whose babies are transferred to the Neonatal Unit immediately after birth and require intensive medical and nursing care due to their poorly condition, cope with the pain they experience. The experiences of their perineum may be different from those of the women recruited to my study and is an acknowledged limitation (see chapter 10).

Summary

Perineal pain and discomfort resulted in the women experiencing new and out of the ordinary sensations such as stinging when passing urine. Movement involving walking and sitting also became restricted, all of which impacted on how women were able to continue with their daily activities. These restrictions ultimately delayed the women's return to the normality, which they had expected to experience almost immediately after birth. Sleep and Grant (1988a) and Harris (1992) identified in their studies that doctors and midwives did not practice from an evidence-base when it came to controlling perineal pain. Disappointingly, poorly managed perineal pain continued to be experienced by the women in my study. Poorly controlled pain also meant some women had difficulty in sleeping. This led to an increase in women's perception of pain, which in turn made it difficult for them to get to sleep. The following chapter moves beyond the immediacy of perineal pain experienced in the early postnatal days to coping with the pain in order to carry out activities related to social expectations.

CHAPTER 7

GETTING BACK TO NORMAL

Introduction

The previous three chapters revealed that perineal pain and discomfort experienced by women participating in this study had an immediate impact on activities related to their personal well-being. This chapter explores that perineal trauma also had a wider impact in terms of the level of control women perceived they had in regard to preventing a tear or episiotomy. This in turn affected how the women came to accept the trauma they sustained and the influence it has on their return to normality. This chapter also reveals that perineal pain and discomfort influenced the dependency women had on others. Part of returning to normal meant women changed from a state of being dependent on others to independently carrying out activities.

Concept and significance of control

According to Ruiz-Bueno (2000) there is no single, agreed definition of control but in general it refers to a person's perception of their ability to alter a situation, response or outcome related to a stimulus. It was important for some women participating in my study to be in control of the birth of their baby. Women who perceived they remained in control during the birth did not view any perineal trauma they sustained as an issue and looked upon it as part of the process of birth.

Fran explains how giving birth naturally this time to Abby, rather than by forceps deliveries with her two previous births, meant she felt she was more in control of what happened:

"I feel not having the epidural, and not having forceps and just actually giving birth naturally and tearing (um), made the recovery a lot quicker and a lot easier, 'cos I only tore as much as I had to"

An example from the literature where women perceive they have the ability to alter a situation is related to the use of water during labour. During immersion in water women can feel almost 'weightless' making it easier to change position, relax and so increase comfort. The warmth of the water may also induce muscle relaxation and reduce anxiety and so facilitate cervical dilatation. Garland (2000) recognises that the use of warm water immersion during labour and birth for relaxation and pain relief has a long history in both lay and clinical care. Hall and Holloway (1998) also demonstrated that for the small group of women recruited to their study (n=9), water immersion during labour increases maternal satisfaction and sense of control. The study was an exploratory design consisting of tape-recorded, in-depth interviews using a grounded theory approach. The small sample of women recruited to the study did not include ethnic or cultural diversity so the findings related to the issue of control in childbirth cannot necessarily be generalised. However, labour was seen by all but one of the women as beneficial, particularly as they felt it gave them more control over the process. The study also found that the support of the midwife was necessary to remain in control. The support of the midwife and the use of water in labour to remain in control of pain enhanced maternal satisfaction.

In contrast some women in my study perceived that they lacked control over the birth of their baby and as a result their perineum tore. These women felt that they were to blame for the perineal trauma and this had an affect on how they came to terms with it. Amanda reflects on her thoughts about loosing control towards the end of labour and what that meant about the resulting stitches to her perineum she had:

"I thought I would be in control all the way through and (um) it's er, really hard actually, 'cos I still find, I still think about it, if we'd done this, or done that, that bit of it wouldn't happen. The only bit before I went in that I was nervous about, I wasn't really worried about being in pain, I was worried about what I'd read about transition and the fact it said people loose control and I thought that's what I don't want to do, and of course that's exactly what happened, because that was so like

prolonged and all the time I was wanting to push I couldn't push, so it was a complete loss of control and I think part of the (pause) psychological side of the stitches and everything that had happened, was me thinking, well you let that happen."

It can be seen from the above quote that prior to giving birth Amanda was confident that she would be able to cope with the experience of labour and be in control of events. Her perception of lack of control only occurred when her experience of childbirth was viewed retrospectively. Viewed from this perspective the outcome of birth failed to meet her expectations.

Amanda was content with being guided by the midwife who would be with her during the labour and birth and supports the findings of Bluff and Holloway (1994) that women believe the midwife 'knows best' what care to give. However, Amanda in the description above appears to doubt the ability of the midwife and questions, 'if we had done this or done that', the outcome may have been different. This view by Amanda appears to challenge some of the findings from the work of Bluff and Holloway (1994).

Anderson and Podkolinski (2000) identify that a predominant fear during the second stage of labour is not remaining in control of what is happening to them, which for many women is the main hurdle that needs to be overcome in order to give birth normally. Being in control can be viewed from a number of perspectives. In a study that explored issues of control, both internal and external, found that women reported greatest satisfaction in childbirth when they were in control (Green et al 1998). Internal control was defined as self-control and was explored by asking participants about control of their own behaviour, control during contractions and the amount of noise they expressed. External control was defined as having control over decision-making and the work health care professionals undertook. The study, which used a scoring system for several questions, also attempted to identify how much control women would like. Control was measured by asking women for their views on having an active part in the non-emergency and emergency decisions that occurred. Women were also asked how much control they would have expected to

have in what health carers did to them. Women were categorised as being 'low control' if they expressed no desire to be in control and 'high control' if they consistently expressed a strong desire to be in control. The results reflected the importance for women being given information and feeling in control, not only for the experience of labour, but also for their subsequent experiences. Women who did not feel in control were least satisfied or the least likely to feel fulfilled. Using these criteria Amanda's following comment suggests that she would fall into the category of 'high control':

> *"I am a control freak and I thought I would be in control."*

Amanda's desire of wanting to be in control could explain why she found it difficult to come to terms with having stitches in the early postnatal days.

> *"Mainly my emotions are disappointment that I needed stitches. Also, I think I keep trying to justify why I tore because I panicked at the end and didn't control my pushing."*

For Amanda her behaviour is also an aspect of control, and links with the work of Goodman et al (2004) where the relationship between having control and a satisfying birth experience was an outcome of their study. In their literature review as background to the study, Goodman et al noted that personal control was a factor related to satisfaction with the childbirth experience and was partly determined with how well women perceived they had managed their own performance. Those who managed it well, by staying in control, viewed childbirth as positive, whereas, those who had difficulty or managed it poorly were more likely to have negative thoughts about their birthing experience. The study by Goodman et al used a convenience sample of 60 low-risk postpartum women who had uneventful vaginal births of healthy full-term infants. The aim was to examine the association of a selection of variables with childbirth satisfaction, which included pain and control. A number of instruments were used to collect the data, including the McGill Pain Questionnaire (see page 96) to assess the level of pain women experienced, the Labor Agentry Scale which measures personal control and the Mackey Childbirth Satisfaction

Rating Scale measuring childbirth satisfaction. Each research instrument has a history of positive validity and reliability for what they purport to measure. The results identified that level of labour pain was less of a predictor of birth satisfaction than having personal control was. The sample size was relatively small and a non-randomly selected so the findings are not generalisable to all postpartum women. However, the findings support other studies that found positive expectations were related to childbirth satisfaction.

The questioning of events by Amanda in relation to how she performed is suggested by Price (1993) to represent an alteration in body image. When women loose control over events related to birth they also loose control over how they wished to present themselves during the birth process. Body image can be simply defined as the way a person sees themselves and perceives how they are seen by others (Salter 1997). The image Amanda wanted to portray was being in control however, this did not materialise. Price (1990b) explains body image as being comprised of three components; the experience individuals have of their body as it really is (body reality); how they would like their body to be (body ideal) and finally how individuals try and adjust their body to achieve their body ideal (body presentation). To maintain a satisfactory body image balance is needed between each component. When they are balanced this contributes to a sense of well-being but failure in any one of the components may result in an altered body image, similar to illness.

In Amanda's example, loss of perceived control illustrates the alteration of body ideal. She had expected to birth with an intact perineum, but did not. Kitzinger (1992a) uses examples from women in her study to highlight an alteration in body ideal with women who have received an episiotomy. Kitzinger (1992a) compares language used by women describing experiences of sexual violence with that of 345 women describing traumatic birth experiences. Women were self-selecting having responded to either an article in the Independent newspaper, to a TV programme or from a book that Kitzinger had written. It was found that when the experiences involved surgery, which included routine practices such as episiotomy, women felt violated. The language often expressed included that of

'assault' and 'abuse'. There were women who believed that the episiotomy was an act of punishment for not trying hard enough in the second stage of labour, not relaxing enough or having unrealistic expectations. She acknowledges that as women were self-selecting information cannot necessarily be generalised to all women but it powerfully communicates the experiences some women may have had during childbirth.

In contrast Ruth's body ideal relating to sustaining perineal trauma, was different to Amanda's. Ruth was more 'matter-of-fact' about her perineal tear and did not give it the same importance as Amanda had given to the perineal tear she had:

> *"...it happened quite naturally. I thought, thought you know just me, it would be there anyway, it just happened. They said his shoulder tore me. I wasn't bothered about it at all. It didn't phase me. When I knew I had a tear it, it was either going to be or not going to be, you can't really do anything about it."*

Ruth believed it was not possible to be in control of her perineum, so trying to prevent a tear was not an issue to be concerned with. Ruth's body ideal was different from Amanda's matching more closely to the reality of what happened. According to the work by Price (1990b) Ruth's closely aligned body ideal enabled her to accept more easily the perineal trauma she had sustained. This was also the case with Fran who was less concerned about her perineum tearing, and more concerned about not having a caesarean section:

> *"I was worried about having a caesarean, I just didn't want a caesarean. I wanted a vaginal birth and I wanted to be able to do it properly this time, without any epidurals or anything. That was my main concern really, that I just wanted to do everything naturally."*

Remaining in control is also about the sharing of information, and is a point well made in Sarah's following comments where she identifies that despite having a forceps delivery she believed she was still in control:

"I know of a lot of people when they fail to breastfeed, fail to deliver naturally and have a C-section, and all the rest of it, you start blaming yourself, but I haven't actually started to blame myself because the midwives did make it very clear that I was doing a fantastic job and it wasn't me, it was just the way his head was coming down. So the fact that I felt exhausted and needed a bit of help, no I didn't feel like a failure and I make sure I don't get that in my mind."

Sarah's comments are supported by the findings of the study by Green et al (1998) where they identified that some women who experience major interventions were still able to feel in control. This is echoed by Fenwick et al (2003) who found that the degree of support and consultation women were involved in when making decisions was a significant factor in how they felt about their birth experience. Women's perception of poor communication left them with a sense of losing or lacking control over the care they received. Green et al suggest that it would be interesting to reflect on what the health care professionals might have been doing to maintain the women's self confidence and feelings of control, even in a difficult labour. The concept of choice and control is not new in maternity care and has been recommended as a central component of any decisions being made by women about their care since 1993 (Department of Health 1993). Control can include women being given unbiased information in order for them and their partners to make informed choices and would have to be gained before any procedure is undertaken. Sarah was very clear that she was kept informed all the way through her labour and the birth, but in contrast this was not the case for Amanda. It appears that towards the end of Amanda's labour, the midwife became rushed in making sure the preparations were ready for the birth. Amanda did not receive the same level of information and support at this time that she would have liked:

"When they said I could push I really pushed to the point that when the midwife went out of the room and I pushed when she was gone and she came back and all she said was 'oh God, I've got to go and get the trolley and it was all a bit quick at the end and when Rhys came out, his head came out I knew then, I knew all along what I had planned to do, how I was going to listen to the midwife and so what I was told and you know, and his head came out I just thought I've had enough and just let go, so he did really fly out. So when they said to me there were three separate tears it just sounded awful."

A key theme to emerging from a phenomenological study by Berg and Dahlberg (1998) related to women's experiences of complicated childbirth, was control. Ten women were interviewed two to five days after the birth of their baby. One of the findings identified having control over a situation increased self-esteem and self-confidence. Sarah's experience and the findings from Berg and Dahlberg's study related to women who had necessary intervention to assist the baby being born. In contrast, despite Amanda having a 'straight forward' birth, she expressed being out of control at the end of her labour, which impacted on how she felt about the perineal tear she sustained. Midwives need to acknowledge that control may be an issue for women regardless of the type of birth they had. This in turn may affect women's satisfaction with the outcome of the birth and how they come to term with what has happened. Difficulty with accepting what happened can impact on how women move on and return to normal.

Raphael-Leff (2001) offers another explanation about why women react differently over issues of control. She identifies two groups of women, 'facilitators' and 'regulators', with the former accepting what will happen during pregnancy and the latter resisting the loss of control which pregnancy and childbirth brings. The 'regulator' fears that the powerful impact of labour will make her vulnerable to losing control and is concerned about making herself look a fool. Labour and birth are seen as a test leaving her worried that she will forget what to do. In contrast the 'facilitator' becomes excited about the forthcoming birth and wishes to labour and birth naturally. She does not want anything to interfere with the process, especially from unsympathetic professionals. These approaches are at either end of a continuum and women can 'sit' anywhere between the two domains and most probably move along the line at various points in time. A criticism of Raphael-Leff's work is that it is not necessarily founded on any research evidence, although her most recent edition cites a number of studies that she argues as supporting her work. Despite this it does offer another view in an attempt to understand how women react in certain situations. Midwives reading Raphael-Leff's work would most likely be able to recall women who 'fit' into one or other of the categories.

Ruiz-Bueno (2000) suggests that by understanding issues of control, predictions can be made about potential responses to health and illness situations and can provide strategies to assist individuals to cope with these situations. Price (1990a; 1990b), following a review of body image literature proposed a body-image care model to assist nurses to diagnose altered body-image more effectively. There are five elements to the care model, body reality, body ideal, body presentation, coping strategies (habitual ways of responding to change) and social support network (people who provide psychological and practical support). The model predicts that individuals who have poorly developed social support networks and who cope with threats to body image in ineffective ways are more likely to develop an altered body image. This model challenges the assumption that particular body changes are necessarily going to cause altered body image, but requires health professionals to consider threats, responses and the coping strategies of individuals (Price 1995). Altered body image as it relates to perineal changes is not something that is commonly assessed in midwifery, but could warrant further investigation to determine if it is an effective tool to help women come to terms with perineal trauma.

Understanding how closely aligned women's body ideal is to their body reality could help midwives understand how women may react to perineal trauma. Midwives are uniquely placed to explore body image with women during the antenatal period helping them to recognise how they may react in the postnatal period and have strategies in place to support this. Exploring body image is not new for midwives but is related more to the exploring changing body shape and weight gain as the pregnancy progresses.

Achieving independence

Women's return to normality involved moving from being dependent on others for help in carrying out activities to managing more independently and requiring less help. For example, because of the restrictions in mobility caused by the perineal trauma and resulting pain and discomfort, women were initially dependent on others to help them

wash. Help was also offered with domestic chores until the women felt able to establish a routine, be more mobile and do it themselves. This move from dependence to independence was an important milestone for women and seen as part of the process of recovery from childbirth and returning to normal. The ability to do housework for example was regarded as an indicator of achieving their goal.

Regaining independence started when reliance on family or the midwife was reduced or ceased to be necessary. This usually began when women were able to carry out aspects of self-care such as personal hygiene needs. Oudshoorn (2005) refers to dependence and control being interlinked and is a state of reliance on something or someone with the result of having less control. To demonstrate this Lawler (1991) in her seminal work on how the body is managed by nurses when intimate contact with the patient's body is required, uses a recovery pathway to identify the reliance and dependency a patient has on a nurse for assistance in looking after body care and body needs. An example Lawler gives is the assistance a patient requires, following surgery or a period of ill health, with personal hygiene and toileting needs. The recovery pathway is based on the belief that a patient will recover from an illness and their dependence becomes less until they are self-caring. Components of the recovery pathway include mobility, feeding and personal hygiene care.

Clare gives an example of this by comparing her current experience of showering after the birth of Laura with having a wash in bed after the birth of her previous baby, Zack:

> *". with Zack I had an epidural so I could only have a wash. Having a shower made a difference."*

Due to the immobilising effect of the epidural Clare was reliant on the midwife to help her wash in bed. Having a wash in bed, or bed bath is generally associated with people being ill or having had surgery and not able to perform the function themselves. Using Lawler's (1991) recovery pathway, this dependence on others, in my view, could be interpreted as a period of illness resulting in confusion as Clare was neither ill nor had she had surgery. This dependence is also suggested in the study by Biley (1992) to determine what factors

affected patient participation in decision-making about nursing care. Biley suggests that adults are capable of looking after their own self-care needs when they are in a state of wellness. When they are not well, self-care deficits occur and adults may then be in need of the assistance. The need to have to rely on assistance is in conflict with the philosophy of childbirth that regards the majority of women as fit and healthy, not unwell (see chapter 3). Women who have birthed without intervention, except for an epidural for pain relief, may find it difficult to accept the help required for washing until the effects of the epidural has worn off and mobility is no longer restricted. With the birth of Laura, Clare was more independent with her washing routine as she did not have to rely on someone else to help her.

Sarah appreciated getting up to shower but in contrast to Clare expected someone to help her. She was surprised that the midwife did not stay in the shower room, especially as she was feeling so weak having lost at least 500mls of blood at the birth. Without help Sarah found it difficult to wash her perineal area:

> *"I was really, really wobbly. Really quite er, really felt quite fragile. Actually one of the, I think she was a Sister or a nurse or something, she showed me where the shower was and where all the bits and pieces were, and I actually thought she was going to help me but she went (laughs)... I didn't wash down there, I just held the shower thing underneath me, and I thought I can't bear to touch it."*

Within the context of the recovery pathway, leaving Sarah alone to shower may have happened because the midwife expected her to be capable of washing on her own. Lawler (1991) explains that when a patient is believed to be capable of recovery nurses maintain control over what the patient is expected to do and the patient is expected to comply with these expectations. Sarah in this instance was expected to shower on her own, with the midwife maintaining control over what she believes Sarah ought to be capable of at this stage of her recovery. Lawler refers to this as the compliance and control rule, which is more appropriate with the medical model of care. Compliance and control does not support women-centred care, as there had been no discussion with the Sarah about what her needs were only an assumption that she could manage without assistance.

A sense of normality began for Sarah after her shower, when she returned to a different room from the one she birthed in. The mess and chaos she left behind in the birthing room was replaced by a clean room with a peaceful atmosphere:

> *"...when I finished the shower and I walked into the room (um), they had moved all my stuff. My husband had moved and the baby was in the room where I was going to spend the night and I walked into that room and it was just so peaceful, and he (the baby) was quite chilled (rested), he just lay there, he was awake but was just (pause) gazing around, and my husband was sat in the chair looking like he was going to sleep, quite badly (laughing), and there was quite a different sort of atmosphere, having gone from this room (pause) which quite honestly was just covered in blood and bits and bobs everywhere to this room which had a bed and it looked all comfy and all my stuff had been moved and I was quite clean, and I felt, ok this is ok now."*

The room Sarah returned to contained familiar people and belongings, such as her husband, and personal items. She felt safe in these surroundings. This is often a reason women cite for giving birth at home; to be in familiar surrounding and have people they know near to them, giving them a sense of control over the process (Chamberlain et al 1997).

Dependence is not confined solely to reliance on the midwife, but in my study the family played an important role as Brenda and Janet found out:

Brenda:
"I've got a lot of support from my family..."

Janet:
"I ended up doing nothing. He (Brian) has had a lot of time off work, Brian has ended up doing that more often because (um), I just can't, just can't, well I can again now, but I couldn't for the first week to ten days I couldn't have walked any distance at all.

The perineal pain and discomfort that Janet was experiencing was particularly bad that she was unable to walk any distance so was dependent on Brian in order to accomplish some

of the activities that were necessary to achieve. Ockleford et al (2004) noted that when women transferred from the hospital to home they suddenly realised they were on their own. If there were family and friends to help this was less of a shock for them. This study was prompted by concerns raised by the local Maternity Services Liaison Committee about postnatal care and support in the community. Maternity Service Liaison Committees provide a forum for women, midwives, doctors and others involved in maternity services to meet together, several times a year, to discuss local maternity services and influence local policies (Edwards 2006). The Committees draw on national guidelines, which promote women-centred care, and looking at how the diverse needs of local women are met.

Ockleford et al (2004) conducted semi-structured interviews at approximately 13 weeks after birth with 39 women from two ethnic groups and two different parity groups. The diversity of the women in the study added to the strength to the findings of the research enabling it to have relevance to a wider population. A criticism of the study however, is that 13 weeks is a long time to recall feelings that may have been important during the stay women had in hospital. The schedule of questions was designed to elicit feelings and opinions about postnatal care they had received, and advice given during this period and on transfer home. In response to questions about leaving hospital, it was apparent that women were often unprepared for their feelings about being at home on their own and whether they could cope. In their discussion Ockleford et al identified that some of the problems encountered by the participants in their study resulted from a mismatch between the women's expectations and the care provided by midwives. When at home the women suddenly realised they were on their own. If the women had family help at home, or were able to easily call for help, they reported being more able to cope. A conclusion drawn from the study was that the post-delivery period was given little attention during pregnancy, the birth being seen as the end-point.

Willingness to accept help from family and friends was critical for women in a study by Hall and Carty (1993), in order for them to have the level of support they required in order

to return home from hospital, without feeling exhausted. The eight women who participated in the study were interviewed before and after the birth. Using a grounded theory approach to analysing data, the core theme, 'taking control' emerged. The women used a number of strategies to take control, which included antenatal preparation to ensure there was going to be family involvement and participation in the postnatal period.

Practical help in the community has been addressed by a study in Sheffield with the introduction of community support workers reproducing the Dutch pattern of postnatal care (Morrell et al 2000). Morrell et al used a randomised controlled trial to establish the relative cost effectiveness of postnatal support in the community in addition to the usual care provided by midwives working in the community. The aim was to help women rest and recover after childbirth by assisting them with childcare and housework. As my study identifies, doing the housework was more easily undertaken when women were able to be more mobile and were feeling less perineal pain and discomfort. The outcome was measured by assessing the general health status of the women, risk of postnatal depression, breastfeeding rates, satisfaction of care, use of the services and personal cost. Health status included aspects such as pain, although there was no differentiation in the study about the type or category of pain being explored. Pain could therefore have included perineal pain, but also breast or abdominal pain, as women who had birthed by caesarean section were also included in the study. Six hundred and twenty three women were allocated at random to the intervention (n=311) or control group (n=312). The intervention consisted of up to 10 home visits in the first postnatal month of up to three hours duration by a community postnatal support worker. The community support worker had received eight weeks of instruction and achieved a national vocational qualification (level 2) postnatal care award plus other recognised training qualifications in care of young children. At six weeks and at six months the results identified there was no significant improvement in health status among women in the intervention group, the financial cost to the NHS was greater in the intervention group and there was no increased uptake in use of social services. In conclusion there was no health benefit of additional home visits by community postnatal support workers compared with traditional community midwifery visiting. However, the

women in the intervention group were very satisfied with the support worker visits, but in a financially stretched NHS, cost implications must be considered before introducing a positively evaluated service by the women, but with no measurable health benefit.

Using random allocation in the study, Morrell et al (2000) ensured the socioeconomic characteristics of the women were similar in both groups, but is unclear if women who were unsupported, socially disadvantaged, in poverty or in poor housing conditions were included. It is identified that the women recruited were more likely to be white and to have an elective caesarean section, suggesting some self-selection among women who perceived the need for additional support. Women excluded from the study were those who could not give informed consent or communicate in English or who had a baby in the special care baby unit for more than 48 hours. Inclusion of a more diverse population of women may have resulted in different outcomes. It is also acknowledged by the authors that the tool to identify health improvement, the SF-36, may have been too insensitive to detect change or distinguish differences in outcomes between groups. The difficulty was that when the trial was being planned there were no relevant measures for evaluating women's experiences of motherhood. Further research is needed to establish the outcomes that mothers themselves value.

In my study, despite accepting help it was important for some women to identify when they could finally achieve something without the help of others. For the women, this was a way of acknowledging a move towards independence and returning to normal. An example of this is given by Sarah when she identifies that initially she needed her husband to help when she was having a bath as she found it difficult to sit because of the perineal pain she was experiencing:

> *"My first bath my husband bathed me, when I bathed at home (laughs). I laid in the bath and couldn't sit up again (laughs), so he did everything, bless him."*

By the fourth day Sarah writes in her diary:

"Had a bath without husband's assistance this morning and actually shaved my legs too!!! Found washing down below less painful."

Sarah is acknowledging her move towards independence and is able to recognise when she achieved something she would normally have done with ease. Partly this was due to the reduced amount of pain she was experiencing in her perineum. Hannah recalls that things were coming together when her husband had returned to work:

"It was actually when Brian went back to work last week. The first week he was home, and then there was obviously people in and out, our parents in and out. I was only (pause), sort of the middle of last week when I was actually on my own all day that I thought it was ok."

My study has identified that initially women are dependent on others to help them carry out daily tasks mainly due to the amount of perineal pain and discomfort they were experiencing. Over a period of time, as the perineal pain and discomfort reduced and mobility improves, the women were able to become more independent and regard this as an achievement. The findings from my study relate to a particular group of women who appear to be supported by their partners. These findings may have been different if a more diverse group of women had participated such as women who are unsupported may have to struggle to achieve a state of independence much more quickly. Midwives need to understand what support is helpful to women and exploring social networks during pregnancy would be an important part of preparing women for after the birth.

Doing the chores

This section explores that as women begin to feel better, are more mobile and have less perineal pain and discomfort, they begin to undertake domestic chores. Keeping up-to-date with the washing and shopping was an aspect of daily living women described as important to achieve. To illustrate this the following examples from Brenda and Clare are given:

Brenda:
"Feel very well today, all household chores completed by 10 o'clock am and I'm even ready myself."

Clare:
"I feel a bit better and have managed to do all of my housework."

Anderson and Podkolinski (2000) suggest the need to do housework is something that is culturally defined. New mothers are expected to continue life as usual, coping with the baby, managing their family and doing the domestic chores (Ockenden 2000; Grabowska 2003). This expectation of women is also apparent during illness as Lumby (1997) reveals in her study about how women maintained involvement in the day-to-day management of the home, despite being unwell. The expectation that 'doing the domestic chores' is women's work, regardless of their state of health could have implications for women who experience severe perineal pain and be expected to continue with the same demands as women having less perineal pain and discomfort.

Care and support to newly delivered mothers has traditionally been provided by women offering help with domestic chores, personal care and care of other family members (Kitzinger 1992b; Marchant 2004). As recently as the 1950s for those in poor or difficult circumstances, practical help from 'home helps' was available to women. The home helps were women employed by local councils to provide practical help in the home to families and others in need (Wynn 1995). By having this support if women were experiencing perineal pain and discomfort that was hindering their ability to complete work within the home, the home help would have supported them by undertaking this work. In Holland Maternity aides are available to look after women and their families in their own homes for eight days following the birth of the baby, to enable them to rest (Tasharrofi 1993). Huang and Mathers (2001) identify that after giving birth women in many cultures are subject to seclusion and postnatal rituals. They are often cared for by women for a period of up to 20-40 days. In Chinese culture this is often called 'doing-the-month' (Heh 2004). During this time women are confined to the home and observe ritual practices such as lying down,

resting and not lifting anything heavy. All these measures are a way of reducing the pressure on the pelvic floor, so any perineal pain and discomfort is not exacerbated. In undertaking the rituals that Heh describes, it is thought that the postnatal condition of women would be bought back to a normal state of health. Rituals are used to transmit the core values of a society to all participants involved in a particular process, such as birth. Davis-Floyd (1987), through interviews with women, midwives and obstetricians, explored the significance of the medical model of birth on American women's experiences of birth. She believes that this approach has led to the erosion of women-centred rituals that in the past protected women from the exhaustion of childbirth.

Jordan (1993) examines childbirth from an anthropological perspective, and proposes that the cultural and social context of birth is as important to women's experiences of birth and wellbeing as is any physical care. Women experience birth within a cultural context that includes social rules and expectations conveying beliefs and values important to the society in which they live. Women are deemed to be at fault for failing to get back to normal, which includes learning to fit the housework into the baby's non-demanding spells, regaining one's waist, making up for lost sleep, visiting the family planning clinic to plan the next baby and generally settling down to a routine of family life.

Brenda acknowledges in her diary how helpful her own mother was in providing support, enabling her to rest and concentrate on mothering her own baby:

> *"Mum came round to do some housework - great, so I only had to deal with myself and Alice."*

In some Western cultures social support has eroded over time, due to geographical location of families or daily employment, with the result those women are often isolated from their own mothers, sisters and aunts. Ruth points this out when talking about the time between giving birth to Ryan and the arrival of her mother a week later by which time she felt exhausted and was pleased to receive the help:

"It wasn't until mum got here on the Monday and whether it's because mum gets here and I emotionally just collapsed in tiredness."

The role of men as fathers has changed over the past several generations, from the detached authoritative figure to the involved parent helping with childcare. However, studies suggest that women still do the majority of domestic chores. Scott and Priest (2002) discuss aspects of baby care that both parents can contribute to but little reference is made to sharing other demands of family life such as domestic chores. A study by Smith (1999a; 1999b) where the views and experiences of a group of new fathers concerning the role classes played in their transition to fatherhood was examined, offered little insight into preparing men for sharing domestic work. Semi-structured interviews were used with volunteers from three National Childbirth Trust courses and four NHS classes. Findings identified that men wanted more information on pregnancy, labour, birth and parenting, with emphasis on parenting being more about baby care and anxieties concerning relationships. This is similar to Barclay and Lupton's (1999) qualitative study into the first 6 months of new fatherhood for a group of 15 men. Although this study is set in Australia the findings still present a useful insight into the experiences of new fatherhood. They interviewed the men on four occasions from a few days before the baby was born until five to six months after birth. They found that when it came to helping with domestic chores men who participated equally in housework before the birth were willing to continue once the baby was born. Men who lacked skills in tasks they had not attempted before the birth were less likely to help out afterwards. Some men considered their paid employment to be the work of the household, and that women should therefore contribute by doing their own household work, which would be the domestic chores. Weekends for these men would mean taking up leisure pursuits similar to before the birth.

When partners did help out women in my study spoke praising their efforts reinforcing it was not a usual occurrence, as Sarah and Hannah comment:

Sarah:
"...because I am breast feeding, (um) when he (husband) was off during the day (um) he was brilliant, I mean he did all the house work and everything without me even having to ask him. All the washing and ironing and everything, he was certainly keeping on top of that. The washing needed to be done. Each time my mum came over she would ask if there was any washing or ironing to be done, but Paul had done it all. They were almost fighting over who was going to do it (laughs)."

Hannah:
"he was as good as gold (laughs). All the things I thought he would not be able to do, he was absolutely fine...I did feel a bit for him because...he's a bit squeamish at the best of times so to send him off not only to do the shopping, but to get maternity pads it was awful."

It appears from both these comments and previous examples from Sarah (page134) that the women recruited to my study were in a relationship where partners were willing to help when needed. Different cultural, ethnic, social and economic backgrounds may influence the degree to which many men actively get involved in 'fatherhood', possibly leading to a different scenario from the one captured in this study. Likewise, if isolated women were in an abusive relationship or one where culturally, it is not expected that the partners help in this way may also have offered a different picture.

McVeigh (1997) suggests that during pregnancy, women should be taught skills about how to 'actively enlist' appropriate helpful support in advance of it actually being needed. Women, and possibly their partners, could be taught techniques such as assertiveness to encourage family and others to help them with important tasks, such as housework, rather than spending time on possibly more congenial activities. This suggestion is one that is only appropriate for women that are able to call on family and friends for support. There are many other women who are isolated and alone or prevented by their partners from making contact with relatives (Department of Health 2005). Midwives have to to be sensitive to individual needs, offering practical help in ways of getting the support they may require.

In contrast to the family support women found useful, Hannah was aware that her husband's parents were less than helpful when they came to visit:

> *"...other people (helpful) no actually. (Um), Brian's parents, bless them eh, I was running round making tea (laughs), which is actually what everyone says they should be doing...I was glad when they cleared off really."*

Women did not always accept offers of help, which Georgina demonstrates by initially taking up the offer of help from her family, but then wanting to carry out the daily chores herself:

> *"I could say goodbye to all my commitments and er, really take a couple of weeks off really. It was like a feeling of being on holiday (laughs) for a couple of weeks. I felt I deserved that for a couple of weeks and just taking two weeks time-out really to give my time completely to Charlotte and myself really."*

Within five days of Charlotte being born, Georgina wrote in her diary that she was doing the housework. When this was discussed at the interview she felt the need to 'get things up together' as she was feeling better:

> *"You know just to, just to do a little bit of housework. Get things up together (um) that was important, yes, yeah. I felt better you know, I didn't like (um), you know, washing piling up and things like that. You know it was nice to be able to get up and do it."*

Despite the help of her family Georgina could see that the clothes washing was not being done quick enough and so felt it necessary to take this task back again and complete it herself. Taking back this task Georgina found possible to do as she was feeling better. Even though she had enlisted the help as outlined by McVeigh (1997), Georgina still felt the need to ultimately do some of the chores herself. This need by Georgina could be seen as a way of acknowledging the return of her independence.

Applying Jordan's (1993) insights about women's experiences of childbirth suggests that the origin of some of the common problems in the postnatal period should be sought not in

physical adaptations after birth but in social ones. Although McVeigh (1993) argues that women should learn assertive techniques to ask for help with the housework, it can be in conflict with women's need to be more independent. Asking for help therefore may be difficult if women want to give the impression they are coping, something that culturally they may wish to portray. Popular magazines, books and the Internet exacerbate this by representing early motherhood as a happy, joyous event (Paradice 1995). Because many of the women's difficulties relate to unexpectedly high expectations of themselves childbirth education could be the forum in which such issues may appropriately be addressed.

Shopping was another domestic chore that was important for some women to undertake. Many modern British women go shopping in the supermarket only a few days after giving birth, where as in other cultures a period of seclusion is adopted lasting up to 40 days (Schott and Henley 1996b; Anderson and Podkolinski 2000). Hannah recounts her fears of David screaming in the supermarket and not being able to cope:

> *"I was quite scared of the prospect of that one (shopping)...I had to get some stuff from the supermarket, I was really worried about that' cos I thought if he screams and I'm half way round the supermarket I wont know what to do and I'll look all panicky and rubbish. When we went to the supermarket I ran round and forgot half of what I needed anyway so it was a pointless exercise."*

Amanda also felt fearful of shopping and expressed her anxieties to her husband, who was going to do the shopping on his own with Rhys, something that Amanda could not imagine being able to do on her own:

> *"I'll (husband) take Rhys with me and I said, well how can you take him? I'll put him in one of those things that the car seat slots in. Yes but you can't, you can't because I was so scared to do it. He said 'I'll be fine, I'll go'. So he did it and in a way that was good for me because he'd gone, he'd done it, so next time I went as well so we all went together, put the baby in the thing. This is how I have to be, it's almost like someone has to give me the confidence to do it."*

Much of the anxiety was around not be in control of the shopping expedition rather than experiencing too much perineal pain and discomfort for the experience to be tolerable.

However, it was an important element that the women in my study felt the need to describe, and shows that when writing about their perineal experience, it is difficult to separate out from other elements that are putting demands of their life. These experiences reinforce the notion that perineal pain and discomfort cannot be viewed by the midwife in isolation from social and emotional aspects of recovery.

Summary

Women in my study saw a need to assert their independence when they began to feel better and therefore more able to carry out the tasks. Feeling better meant an improvement in a number of physical changes following the birth including a reduction in perineal pain and discomfort as well as the ability to be more mobile. Feelings of being tired as well as the baby establishing a routine were also contributing factors. Issues related to the perineum were an important factor to feeling better and getting back to normal, but were not the only ones, and women felt the need to describe more than just perineal issues in their diary and at interview. Perineal pain and discomfort cannot be viewed in isolation and needs to be seen and managed holistically. It has been identified that following childbirth the women in my study experienced pain, had difficulty with passing urine and having their bowels open, as well as problems with mobilising and sitting comfortably after childbirth. The women needed to manage these symptoms early on in the postnatal period in order to attempt to undertake more complex daily activities.

CHAPTER 8

RECOVERY OF SELF

Introduction

The previous chapter identified that following childbirth women attempted to carry out daily activities that were related to cultural and social expectations. The activities were attempted when their perineal pain and discomfort felt better and they were more able to be mobile. Completing activities such as domestic chores gave the women a sense of achievement enabling them to move towards their goal of returning to normal. This chapter describes how the perineal trauma women sustained made them feel differently about their body. It explores what made them feel different, how they wished to return to their normal selves and the steps taken to achieve this. The chapter concludes considering women's recognition and descriptions of their journey in which they return to normality following the birth.

After the birth of their baby women were much more conscious of their perineum, and imagined the worst about the trauma; what it looked like and the long term effects it may have in their return to normality. Initially women were reluctant to look at their perineum in case the trauma was as bad as they thought, although they reported that in reality it was often better than expected

Imagining the worst

The perineum and surrounding muscle and tissue are not normally an area that women are consciously aware of and its function is often taken for granted. Consequently when injury occurs, any pain and discomfort or swelling becomes acutely noticeable. The perineum is not an area that is easily visible to women so the extent of tissue damage can remain

hidden leaving women to imagine what it might look like. They imagined it to be visibly worse than the trauma actually was, and this was associated with a reluctance to look and find out. Hannah illustrates this by vividly recalling her conviction that if she looked at the stitches it would be worse than she could imagine:

> Hannah:
> *"I sort of (pause), I didn't really want to know (pause), I suppose it would have made it feel worse. Yeah, I sort of (um), half convinced if I saw them (stitches) I'd be absolutely more horrified than I was in the first place."*

An early study by Henker (1982) provides a useful insight into emotional reactions of women following surgery to their sexual organs and the resulting perception of body image. Henker refers to the surgical scarring as mutilation and the woman's optimal mental picture of herself as being spoiled, which invariably triggers some emotional reaction from the woman. This study refers primarily to surgical procedures such as hysterectomies and mastectomies but episiotomy is also a surgical intervention and done to a sexual organ, so could arguably be included in this list.

Kitzinger (1986) gives the example that a small knot of scar tissue may become magnified in the woman's mind to a size of a large walnut. Tunnadine (1992) also identifies women who believe they have changed in some way 'down there' following an episiotomy and if a 'slight asymmetry' or 'bubbly vaginal tissue' is noticed, there follows the imagination of lumps and serious damage.

The perineal scar that Sarah was left with after giving birth caused her concern. She was worried about the overlap of skin that was left at the base of her stitches:

> *"My midwife has told me that where the stitches end there is some "puckering" or overlapping skin which has caused a lump... The "puckering" is quite prominent and explains why it hurts so much!! It looks like this...(diagram given in diary)."*

The episiotomy Sarah required in order to facilitate the birth of her baby by forceps has similarities with other surgical incisions that alter the appearance of the body. Tait and Wing (1997) offer advice about how best to support women who have had body-altering surgery due to breast cancer, leaving the women with an inevitable scar and could usefully be considered by midwives when talking with women about their perineum following birth.

Tait and Wing (1997) suggest when the dressing is first removed the reality of loss can be traumatic, so sensitive handling by the nurse is important. In relation to perineal trauma, unlike other wounds, a dressing is not applied but instead sterile sanitary towels are encouraged to be changed frequently. However, the sanitary towel may have similar significance for the women as a dressing and if midwives are to look at the perineum, then this needs to be done sensitively. Tait and Wing recommend that during this time the patient should be encouraged to look quickly at the wound, before it is re-covered. However forcing the issue can be counter productive and some women may continue to cope by avoidance tactics. Midwives could learn from this study in that the decision when women should look at the wound must remain with them. This was clearly so for Fran who did not wish to look at her perineal trauma. Fran had experienced stitches with her two previous births and talked about not wanting to know:

> *"I've never looked at my stitches...I didn't want to know – ignorance is bliss... So I didn't, I just didn't want to look."*

It is more difficult for women to view their perineum, and may be something they have never done before, due to its location. It is hidden from view and most likely to be regarded as a private part of the anatomy. Because of the location of the perineum the midwife should advise women about how best to view it such as looking in a mirror when next visiting the toilet. Tait and Wing (1997) suggest it is never helpful to tell women they have a lovely scar, or that it looks good, but it can be helpful to ask how they feel about it. Finally Tait and Wing advise that in order for the nurse to realise the impact of altered body image on a woman, she needs to have some baseline assessment of how much body

image matters to the woman prior to her diagnosis and treatment. This is an area of discussion that is lacking in midwifery and would warrant further investigation to determine the effectiveness of this assessment.

Not as bad as I thought

Some women did eventually go on to look at their perineum, and were pleasantly surprised.

> Amanda:
> *"When I actually looked, the stitches weren't so bad and looked though, you know, the tears were healing up a little and that was really good. ...you know as I say I had thought it would be a lot worse and (um) then each day I would have a look and think, oh yes that looks better, (um) and everything still looked normal, where it should be, which was a relief."*

> Sarah:
> *"...(Um), it actually looked, by the time I managed to look at it, it did look a lot better than I thought it was going to. I thought it was going to be a lot more (pause) bloody than it was. But I had made a real effort to keep it as clean as I physically could and I was bathing two or three times a day. So it didn't look as bad as I thought it's going to be actually, not half as bad".*

The above descriptions powerfully demonstrate that when the perineum was visualised by the women, the trauma did not match in their minds the degree of pain they were experiencing. This has implications for the way in which midwives assess the intensity of the perineal pain women are feeling, and cannot be based alone on the appearance of the trauma. Assessing pain based on the visual state of the perineum rather than listening to women may be why they are not believed about the degree of pain they are experiencing. The visual state of the perineum may not give the true effect of the amount of pain being experienced (see chapter 5).

The perineal pain and discomfort the women were feeling meant they were more aware of their perineum than usual. Madjar (1997) suggests that pain provides a stimulus for concentrating on the part of the body that is in pain. When that particular part of the body is functioning individuals become more aware of it and how it may appear to themselves and others. For the women in my study the pain and discomfort appeared greater than the amount of trauma sustained which with Madjar's reasoning could be due to perineal pain being an unusual experience and when felt, concentrated the minds of the women to that particular area.

Women having difficulty viewing their perineum and what they imagined the trauma to be like has parallels with women whose babies was stillborn. There was a noticeable mismatch by the women with the perineal pain they were experiencing and what they thought to be the amount of trauma they had sustained. Women also imagined the worst when they had a stillbirth and the baby was removed from them without being offered time to touch and cuddle it. Removing the baby as quickly as possible has often left parents with a sense of unreality resulting in fantasies about what their baby looked liked. What was imagined was far worse than the truth (Penson 1990). It is now recognised that many parents have a need to hold their stillborn baby. This example is included to demonstrate the fear and exaggeration of the unknown.

Imagining what the perineal trauma looked liked extended to the women's partners. Amanda's partner witnessed the perineum being stitched and Sarah's partner witnessed her perineum being cut, both of which created issues for their partners.

> Amanda:
> *"He sat in the corner holding Rhys and he said he didn't really look, but you couldn't help but see, so he actually said to me (laughs) sometime last week, 'can I have a look, because I am really frightened of what happened to you', because all he'd seen was blood and he said you know, because I'd said to him, 'it's all getting better', 'can I have a look because I'm really scared of what I saw'. So that was good because he like, oh God, yes you know, you look normal."*

Sarah:
"he'd seen her cut me, he did watch it, he watched the whole, he watched the whole forceps delivery and everything, because he was down that end. He said I do think I can empathise with what you are going through...Two days ago he actually looked at it and said, 'oh it's not that bad'. It was sort of, what's that, what's that where it was gaping."

As these two accounts demonstrate it is important for midwives to be both sensitive to where the partners are positioned at the time of the birth and afterwards. There is little documented information in professional literature about the short-term and long-term effects for both partners and their sexual relationship after a shared birth experience. Longworth (2006) notes that for some fathers witnessing the birth may have a significant negative effect on the couple's sexual relationship and Hall (1993) points out that if the birth becomes complicated, as with a forceps delivery, men have been known to lack sexual interest in their partner through fear of putting her (and themselves) through the experience again. Midwives should encourage women and their partners to discuss their fears and feelings about what is right for them as individuals, as well as what is right for them as a couple and their relationship. O'Driscoll (1994) suggests sexual matters with both partners should begin to be addressed in the antenatal period and continued through into the postnatal period. Although many fathers are present at the birth of their child, midwives should not expect that this is right for all men. Neither Amanda nor Sarah commented that any of these issues were addressed in the antenatal period although it was not an issue specifically asked about in my study. As previously discussed in chapter 4 women would self select information they believed was relevant at the time, so details may have been given but ignored.

It must also be recognised that Amanda and Sarah appear to be in supportive relationships and able to discuss their perineum with their partners. This may not be so if women are in a 'difficult' or abusive relationship where their partners observing the suturing may leave the women feeling powerless and submissive.

Dawson (1997) suggests that large or small gynaecological operations involve organs that are of special significance in a woman's concept of herself as female. Some women in my study made the connection between the pains they were experiencing and the trauma sustained with perceived future difficulty of wanting more children. Women also acknowledged that having sex was too difficult to think about due to the perineal pain experienced. Sarah conveys this clearly:

> *"dealing with things (um), that you obviously didn't have planned down there, I was wondering God is it ever going to be ok to have sex again those sorts of things, normality being obviously that side of things as well and I was just can't ever imagine wanting to be if I'm honest. I know I will but it is hard to imagine (laughs)."*

Sociocultural attitudes can affect the resumption of sexual enjoyment after childbirth (Stewart-Moore 2000). The Western cultural image of normal family life includes women resuming a full sexual relationship with their partner within weeks of giving birth (Robinson 1998), yet 50 percent of women experience difficulties associated with intercourse in the first year after childbirth (Glazener 1997). Issues such as loss of libido, tiredness, adjustment to motherhood, breastfeeding, perineal discomfort, vaginal dryness and body image can all influence women's decisions about the timing of resuming intercourse (Reamy and White 1987). In contrast many traditional African cultures would not expect women who are breastfeeding, to resume sexual relations with their husbands for up to two years following the birth (Anderson and Podkolinski 2000). The study by Hay-Smith and Mantle (1996) found that instrumental delivery and / or a painful perineum at 24-48 hours were predictors of later difficulties with intercourse. This was based on the findings of a survey they conducted with 103 women, all of whom had had normal deliveries. They asked women to complete an anonymous questionnaire about difficulty with intercourse after childbirth (dyspareunea). Superficial dyspareunea after childbirth was experienced by 50 per cent of the respondents. When women were asked about it, few reported confiding their problems about sexual intercourse to doctors or other health professionals. One of the reasons for not consulting a health professional was that they thought the pain would go away.

Trials carried out by Gordon et al (1998) and Mackrodt et al (1998) found that 44-46 percent of women who had resumed intercourse at three months postpartum had experienced superficial dyspareunea and 15-19 percent continued to have pain. Hay-Smith and Mantle (1996) recommend that midwives prepare women with a higher risk of morbidity by making them aware of local services for dyspareunea. This may prove difficult, as my study has identified that women did not readily accept advice related to perineal trauma before birth. It would be necessary therefore, to follow through any advice into the postnatal period and relate it to the assessment of pain at 24-48 hours. It would be important to remember that it is the assessment of the intensity of pain that is the indicator of future morbidity and not necessarily the degree of trauma sustained.

Postnatal women and their partners need to know what to expect when resuming sexual intercourse and how any discomfort can be prevented. Women and their partners need also to know what not to expect, for example excessive pain, so they will know what is abnormal and when to seek help.

Feeling different

Feeling different was noticeable by the way women attempted to move and walk around. The significance of walking and sitting has been discussed in chapter 6 where it was noted that undertaking these activities often caused more perineal pain and discomfort. However, attempts by the women to walk and sit also made them think they looked awkward as their movements were often slow and stiff, a stark contrast from how they could undertake these activities before giving birth. Fran and Hannah had clear memories of how they thought they looked when walking:

Hannah:
"... while walking like John Wayne!"

Fran:
"...I felt like a duck (laughs) ...when you have big pads as well, everything feels large and then you have this massive pad, you know like, (laughs) you know."

Ruth could also recall how she felt when trying to get up off the sofa:

"I was more like an old woman, getting up (off the sofa) really slowly (pause) awkwardly,"

The descriptions women offered portrayed an image starkly different from their 'familiar self'. Madjar (1997) would describe this as a loss of their familiar body, accentuated by looking and feeling different. The description of self according to Oliver (1993) is not always favourable and not necessarily objective, highlighted by Fran and Hannah's comments above. The loss of a familiar body was an issue for Sarah explaining how the size of her sanitary pads made her feel like she was wearing a nappy and that it was a significant moment when she was able to wear thinner pads:

"Have changed from large thick towels to thinner ones with wings which makes me feel less like I'm wearing a nappy and also makes sitting down easier...when people are here and you've got big old thick towels and even in tracksuit bottoms people can still see that it's there. And I know that anyone who has had kids, knows you've got to wear them, but I was like, I didn't want people to see me wearing them."

Sarah felt embarrassed, and found it difficult to be objective about how she looked, despite knowing people understood that wearing sanitary towels was an expected part of childbirth. This embarrassment can be linked with cultural norms with the expectation that menstruating is a private affair (Schott and Henley 1996b). This is especially so if menstruating is seen as something that is 'unclean', and so should remain hidden. Recently menstruation has become more public as the media starts to advertise sanitary wear during prime time television viewing. However, the sanitary wear is depicted by its 'invisibility', marketing it by showing women wearing tight fitting clothes, reinforcing the desirability of menstruation being hidden.

Dawson (1997), a Macmillan Cancer Nurse links this view of 'remaining hidden' to the importance society places on outward appearances and how from an early age girls are expected to be graceful, attractive and to stay clean. Dawson makes reference to how the media's portrayal of women reinforces the view that women's bodies are essentially decorative and an aid to selling from soap powder to cars. She uses her experience to explore issues related to gynaecological disorders and the threat to femininity the disorders can bring. The examples that Dawson refers to reinforces the importance that society places on women about how they look rather than who they are. If an individual's appearance is then altered in someway, that they perceive does not positively enhance their looks, then this can result in a loss of self-esteem. Sarah, having to wear thick sanitary towels that were noticeable as well as being uncomfortable to wear when trying to sit down, was a threat to how she thought she looked.

Wanting to be myself again

Some women saw the initial wash after the birth as a process that would allow them to begin to feel like themselves again. This also included aspects such as wearing their own clothes, feeling feminine and beginning to contemplate sexual intercourse. Women also acknowledged their return to a more normal self by reflecting in their diary the recovery they had achieved so far. Self in this context is about women returning to a known personal self rather than a 'self with child'. The return to 'self with child' is about becoming a mother (Barclay et al 1997), whereas in my study returning to self for the women was about wanting a normality that they were familiar with.

After giving birth, part of the care provided for women is helping them with their initial personal hygiene needs, which includes washing with assistance where needed. Georgina explains the initial wash was the time when she felt she had started to feel more like herself again.

Georgina:
"...but really I just wanted to get into the shower to be honest. I didn't want to sit there and feel mucky (laughs), I wanted to get into the shower. It's being clean and back to me..."

Washing in the context that Georgina describes is not just about getting clean but also to do with issues of social desirability and acceptable presentation of self to others. Schott and Henley (1996a) refer to personal hygiene being loaded with significance and emotions citing that people are often judgemental of those whose standards of personal hygiene are different. McCormick (2003) illustrates this by recommending that when women are admitted to hospital in labour, and have not had access to a bath or shower, the hospital facilities should be offered.

Beliefs and practices in relation to washing and cleanliness are linked to health, social acceptability and to personal comfort and wellbeing. The vast majority of cultural differences lie along a spectrum of normality, on which no one way of doing things is better than the other. Washing and cleanliness for some is linked to prayer, sexual intercourse and medical examinations. In most cultures some or all bodily secretions, including faeces, menstrual blood, urine and semen are regarded as dirty or polluting. In Lawler's study (1991) the body is describes as a symbol of dirt. Lawler explored how nurses construct a view of the body enabling them to carry out intimate acts of caring related to bodily functions. In the context of midwifery, this could refer to how the midwife discusses with women about keeping their perineal area clean and dry, especially if it has been stitched, in order to promote healing and prevent infection. At times the midwife may need to help women clean the perineal area and change their sanitary wear, if she is immobile for any length of time following the birth. Hannah had a forceps delivery and episiotomy was feeling particularly uncomfortable as her diary entry from a few hours after the birth of David identifies. Her description gives an example of when the midwife would need to help with personal hygiene needs:

"I feel like I can't possibly move my legs ever again!... Not helped by the fact I still have a catheter and drip attached. Also am bleeding excessively (it feels excessive

anyway) and due to lack of movement I am convinced I am sitting in a pool of blood...there has been absolutely nothing I can do about it as I cannot move from the bed."

The interview data from the study by Lawler (1991) shows nurses learn through experience to touch and handle other people's bodies in ways that are deemed non-sexual and minimizes embarrassment. This is achieved by defining the situation as a professional encounter, displaying a 'matter of fact' manner, careful use of language, avoiding exposure of body parts, the use of humour to minimise embarrassment and the expectation that the patient and the nurse will behave 'properly'. Lawler concludes that the literature used in her study supports the notion that all societies have ways of dealing with the body, body products and dirt – irrespective of how it is defined. It is also clear that there is a very close relationship between body, sexuality and dirt, and the social behaviour related to them.

Midwives reinforce the notion of body parts and bodily functions being dirty by the language they use and the procedures they carry out. Stewart (2005) provides an example in relation to vaginal examination undertaken during labour to assess progress. During a period of non-participant observation it was noted that some midwives attached great importance to the way in which women were physically prepared for vaginal examination. Sterile vaginal examination packs were placed on trolleys and women's genitalia washed in a specific way. Stewart determines that this wash-down procedure practised by some midwives could be a ritualistic way of dealing with their own discomfort about performing such an intimate examination. Stewart observed however, that not all midwives carried out this procedure particularly if the women were labouring at home and so suggests that ritualistic washing of the genitalia prior to vaginal examination may also be related to expressing professional control by the midwife. In support of the midwives preparing women for vaginal examination in a way to manage their own embarrassment, Lawler (1991) suggests that healthcare professionals use rituals to make body care and its related 'dirty work' socially manageable. Midwives should reflect on this in relation to how they

approach women when it is thought necessary to inspect their perineum to assess the extent of trauma or healing for example.

Understanding that language can reinforce the notion that body parts are seen as 'dirty' led me to reflect on the language I have used in the past:

> *"I have used language to describe the act of giving birth as 'dirty work'. Early in my student days I know I have said to women during the second sage of labour and heard being said to women, 'push as if you are having your bowels open'. I also remember having a discussion with a midwife, whose views I came to respect, that this language was not appropriate to associate with birth. If women connect having their bowels open with giving birth, they will be embarrassed and reluctant to push."* **June 2004.**

Ritualised washing-down extends to the birth itself, with textbooks in the past offering descriptions of ensuring a 'sterile field' around the woman in preparation for the imminent birth of the baby (Hickman 1978; Sweet 1984). This was to reduce the risk of cross infection to the baby, but was based on little evidence. Now there is the evidence, such as the study by Keane and Thornton (1998) that confirms if the birth is straightforward, the need for strict asepsis is not necessary.

Own clothes and possessions

Price (1990a) suggests that putting on familiar clothes becomes part of a picture of returning to normality. Wearing personal clothes in hospital has been a debate in midwifery in the past, where women on entering hospital were expected to remove their outdoor clothes and put on a hospital gown. Davis-Floyd (1987) refers to this practice as a ritual to draw birthing women into conformity similar to an assembly-line production of goods. Wearing a hospital gown, being tagged with an identification bracelet, having their pubic hair shaved and being given an enema was all part of the 'preparation' women were subjected to on entering the hospital in labour. Davis-Floyd argues this process symbolically stripped women of their individuality, autonomy and sexuality in order to

become institutional property and conform to hospital expectations. Much of this practice has changed, especially routine perineal shaves and enemas, as there is now the evidence to identify there is no increased risk if infection to the baby by not carrying out these procedures. Often, this ritualised practice was cited as a reason why women wanted to birth at home, as they were able to wear their own clothes and maintain their personal identity and feel in control of what was happening (Chamberlain et al 1997). The ability to wear again familiar clothes was an important step forward for Ruth as the following example illustrates.

> *"I, er, I (pause), was in my own clothes after three days and that made me feel as if, 'oh I can get into them again'. That was quite a, I don't know, I just wanted to be back into my own clothes"*

In contrast Sarah found it difficult having to wear clothes at night-time as this was something she was not used to doing:

> *"...at one point I thought to myself, God you've even got to continuously wear knickers. Which, actually I could have not done with doing that either. I read somewhere that you could just lay in the bed on a towel, without any knickers or towel on and let the air get to it (stitches) and that would be a good thing, but I just couldn't bring myself to do that yes, having to wear knickers all the time, because I don't generally wear anything in bed. So all of a sudden you go from wearing nothing to wearing a massive towel with knickers, and because I am leaking I have to wear a bra top with pads as well, so it is er, it is er, different."*

Sarah is expressing difficulty coping with milk leaking from her breasts and bleeding from her genital tract, which Tinsdall (1997) identifies with suggesting that the physical changes women have to cope with can cause problems. The problems include leaking from so many orifices that maintaining standards of hygiene that they are used to is problematic. Brenda illustrates this with the following quote:

> *"I feel a bit dirty down below, probably because I am not used to bleeding and having to wear a towel, it's been 9 months period free. I bath and shower daily but still feel dirty."*

Relating menstrual bleeding to feeling dirty is not uncommon as some cultures have restrictions on what women are able to do after childbirth and while menstruating. For example in some Indian cultures it is forbidden for the new mother to enter the kitchen because she is 'unclean'. The wider family cares for the woman for several weeks before she resumes her household chores (Scott and Henley 1996a, Tinsdall 1997). Yearly (1997), refers to traditional societies where the blood of childbirth and ensuing lochia are considered to be highly polluting since they are particularly alluring to evil spirits. Therefore women are often segregated and isolated from the rest of the community and forbidden to cook in case she contaminates the family's food.

Recognising the recovery so far

It is acknowledged that in my study the diaries were only used for 10 days following birth but by completion of their diary several of the women referred to resuming sexual relations with their partner, or having another baby in the future. This was a stark contrast to the beginning of the diary where Amanda for instance, due to the pain and discomfort she was feeling in her perineum, could not contemplate having any more children.

> *"the biggest fear is that this will put me off ever having any more children even though it's very early days. This really does scare me."*

On day 5 Amanda wrote in her diary:

> *"Still not sure about sex before my six week check though."*

But by day seven Amanda was able to joke about sex:

> *"Jeremy and I even managed to joke about sex this morning!"*

Feeling comfortable about resuming sexual relations with their partner in the future was felt by some women in my study to be beyond their realisation by the end of the ten-day period they kept the diary for. Sarah clarifies this in her diary entry:

> *"We (Sarah and husband) laugh about it, but really not being able to use my equipment plays in my mind while I sleep."*

The recognition by Amanda of changing attitudes to the consequences of perineal trauma was important to women in being able to recognise how much progress they had made in returning to normal over a short period of time. The diary was a catalyst that enabled women to reflect over the previous nine days since the birth to see the changes that had taken place:

> Debbie:
> *"Keeping this diary has made me more conscious of what my body went through during labour and birth and I think I have worked harder to return to normality because of it."*

> Amanda:
> *"The other thing is that after delivery I was so scared that I honestly never thought I'd get over it and would never, ever be able to consider going through it again – the tearing was a major factor in this and I was sure I would just split in two if I was ever to try. But, already I seem to be getting more philosophical and thinking it wasn't so bad and of course everything will heal and I'd be ok. Amazing – I was sure I'd never think like that, let alone this soon."*

In some cases the women who had given birth before remarked when I went to collect their diary that they had not really written much, but would have done so with their first baby. This was recorded in my field notes as follows:

> *"it is interesting that when I go to pick up the diary the women mention that they would have written more had it been their first baby. They have obviously given thought to differences that had taken place between this birth and the one previously. It would be helpful to explore this further with these women but have no means of doing this at the moment."* April 1999

These experiences and others described in the methodology chapter prompted me to consider the possibility of interviewing the women a few weeks after collecting and initially analysing their diary.

Women in my study appeared to welcome the opportunity to write and talk about their birth experience, especially as the actual experience differed from their expectation. Hall (2001) suggests that where birth has historically been a social event that included group participation of the women in the community, story telling may not have been necessary as everyone would have known by being there, what had happened. Since birth has become an isolated event women are now using a different medium to let people know about the events that took place during the birth. Supporting this view, Barclay et al (1997) used nine antenatal focus groups with a total of 55 women to discuss the experience of becoming a mother. Women found the reality of becoming a mother to be different from their expectation and reported that being able to narrate their birth experience repeatedly allowed them to accept the reality. The process of women telling their story may serve to highlight the discrepancies between the official stories recorded by the health care professionals and the perception of the women concerned. The process of women telling their story is also referred to in chapter 5 where it was recognised that women experience childbirth as a traumatic event for which they may need counselling or debriefing to explore issues and come to terms with what happened. Facilitating women to tell their story in the context of this chapter is different and is something that most of the women in my study did spontaneously as part of their diary keeping. Debriefing and telling stories must be seen as separate concepts, the latter being undertaken by many women as part of a normal process.

It was not the remit of my study to explore the importance of the need for women to retell their experience of birth and there is literature that documents the advantages and disadvantages of such a process (Ralph and Alexander 1994; Hammett 1997; Marchant and Garcia 2000). However, the use of diaries may be considered as another medium to help facilitate women's understanding of their experience.

The findings and discussion presented in this study have identified the importance for women to return to normal. The pathway that the women took to reach this goal depended on the amount of perineal pain and discomfort they were experiencing. Firstly the women in my study attempted to manage the perineal pain and discomfort they were feeling and also made adjustments in order to cope with carrying out daily activities related to bodily functions. When the women felt better they began to undertake domestic tasks in order to maintain a predictable home environment. Recovery of self was a final stage towards their return to normality. Important to the women in their determinants of returning to normality has similarities with Maslow's 'hierarchy of needs'.

The book in which Maslow first proposed his hierarchy was called *Motivation and Personality*. The essence of Maslow's theory of hierarchy of needs is based on human motivation (Eysenck 1998); motivation in this context being concerned with why people think and act the way they do. Motivated behaviour, from the psychologist's perspective is purposeful, that is, the need to achieve goals drives motivation. There are different psychological theories that explore the underlying motives to achieving goals. For example psychodynamic psychologists, such as Freud, would suggest there are internal, unconscious drives that motivate individuals to achieving goals and these drives are beyond the control of the individual, whereas biopsychologists would study bodily events and processes taking place in the nervous system and endocrine system or interaction between these different systems (Gross 2005). Maslow's theory is developed from the humanistic school of psychology where understanding what drives motivation is viewed in terms of a hierarchy of motives where 'realising ones full potential' and 'becoming everything one is capable of becoming', is at the top of the hierarchy. Humanistic psychologists believe in free will and people's ability to choose how they act. They acknowledge individuals as interpreters of themselves and their world. Therefore behaviour is understood in terms of individual's subjective experience, which is regarded as a strength of the humanistic approach (Eysenck 1998). Humanistic psychologists would also regard other strengths of Maslow's hierarchy of needs being that it focuses on the

conscious rather than behaviour, on understanding rather than prediction and control and discussion rather than experimental methods (Eysenck 1998).

According to Maslow the needs at the lower end of the hierarchy are survival and are driven by satisfying basic physical and psychological needs such as water, food and sleep. The women in my study were motivated to achieve freedom from pain and improve mobility and sleep. The next level relates to safety needs and includes a secure and predictable environment relatively free of stress and anxiety. Women's descriptions in chapter 7 identify a need to have a predictable environment where routine is important especially when ensuring domestic chores are complete. When other individuals in the household did not achieve this to their satisfaction, the women would carry it out themselves to reduce the stress. An example given previously was Georgina noticing the washing piling up, which caused her a degree of anxiety.

Moving up the hierarchy the needs become linked more to life experience and less to do with satisfying biological needs. Eysenck (1994) identifies that there has been challenges to Maslow's view of self-actualisation as being the ultimate goal. The criticisms centre on very few people attaining self-actualisation. Maslow also refers to the hierarchy as a linear process where one level of needs must be achieved before moving onto the next level. In reality this may not always be the case and individuals may move up and down the hierarchy as circumstances dictate. Carl Rogers, another psychologist from the humanistic school, talks about the 'actualising tendency' reflecting the individuals desire to grow, develop and enhance their capabilities (Gross 2005). It could be argued these desires are more compatible for women taking on their role as mothers, with striving for normality being part of the process.

In the short period of time women wrote in their diary there is little to connect their thoughts and feelings to the higher levels referred to by Maslow. However, there would be merit in repeating this study and extending the time frame to explore if the higher levels referred to by Maslow have parallels with achieving transition to motherhood. Making a

successful transition to motherhood may be one of the drivers to realising women's full potential as a mother and personal growth and development is part of the process.

Summary

In this chapter the category, 'recovery of self' has been explored. The various ways in which women felt different from normal and how they strove to regain a familiar body has been identified. The women in this study who were having their first baby found the pain experience influenced how they imagined their perineal trauma looked, which was often disproportionate to what they actually saw. Pain and discomfort also affected how they moved which gave an outward appearance of looking different. The initial wash for women was important in order to help them feel more like themselves again and was enhanced by wearing their own clothes and having familiar possessions around them. Keeping a diary was a means by which the women could assess the progress they had made towards their recovery of self.

Humanistic psychology incorporating Maslow's 'hierarchy of needs' provides a useful backdrop in offering a framework to understand the stages women undergo in their strive for normality. The humanistic approach acknowledges women as individuals and stresses the importance of understanding women as a whole person rather than separate systems. Issues surrounding perineal pain and discomfort are vital to women in the process of their recovery but other factors are also play an important part for the women in their strive for normality.

CHAPTER 9

PERSONAL JOURNEY THROUGH THE RESEARCH PROCESS

Introduction

This chapter contains reflective comments about my journey through the life of this study acknowledging personal experiences, which may have influenced the collecting, understanding and interpretation of data. The reflection will include what I have learnt about myself from undertaking this work, as well as what I have learnt about the process, what went well, what I would do differently next time and limitations to the study.

Reflection is an important part of the research process and has been discussed in some detail in the methodology chapter. People have the ability to construct meaning from their own perspective and on this basis individuals may interpret events differently depending on their experience of the event and the background that has led them to that event (Mulhall et al 1999). Being explicit about this will help anyone reading my study to understand the findings and the discussions within the context of what I bring to the study. This is a view held by Carolan (2003) in her personal journey during data collection for a study exploring the transition to motherhood for first time mothers aged over 35 years. She was aware of the tension between her role as a midwife and the image she was supposed to portray as a researcher. The tension escalated when Carolan heard herself on tape when transcribing the interviews and realised how much she slipped back into her clinical role when talking with the women. As she became more experienced with the research process Carolan began to learn how, as a researcher, she impacted on the data gathering and how important critical analysis of the role was.

My starting point for this research was a belief that women have the ability to birth naturally, with only a small percentage requiring obstetric intervention to assist in the process. The percentage of pregnant women who do birth naturally can differ depending on the definitions used for 'naturally' and 'obstetric intervention', (see

chapter 3). My own philosophy is based on the holistic model where women are at the centre of care. An important part of the philosophy is that women are given unbiased information from health professionals to enable them to make informed choices about the care they wish to receive. The choices that some women may make could cause significant risk to their baby or themselves but providing the women have made their decision knowing all of the facts then their decision should be respected. In order to support women appropriately in the decisions they have made I believe there is a need to hear what women are saying and to understand women's experiences from their own perspective. As the nature of my study implies I believe it important to understand the world as seen through the eyes of women, rather than construct their world on the basis of observation from outside, by others. Hence the background to this research is to understand the experiences women have, from their own perspective, about a particular issue related to childbirth.

The aim of this study was to understand women's experiences of their perineum following childbirth, an interest that developed from my Master's Degree (see chapter 1). I have achieved this aim and was interested that the core category, 'striving for normality' was not what I had expected, but in hindsight I was not surprised. From the findings of my previous research study I had anticipated that body image would be more of a focal point for the women. However, through the process of undertaking this study I can now understand why women have a wish to return to normal following birth. Many of the experiences the women describe, such as the pain and discomfort they felt, impacted on their daily living and were out of the ordinary. In order to feel more like their normal selves the women wished to return to normal.

It was apparent early on in the diaries that the women filled in, that they usually began by setting the scene about their birth, something that I had not particularly asked for but was important for them to express. The women for example would describe how long their labour had been, when they came into hospital and what sort of pain relief they had. I understand now from reading some of the literature about telling birth stories, that women feel a need to tell the whole story. Telling birth stories helps to confirm to the women the reality of the experiences they had especially when their expectations had been different. Through narrating the story women are finding a way of trying to

understand what happened (see chapter 8). The whole story for the women in my study began with the birth, and this put into context the particular experiences they had in the postnatal period. This may be a way of them making sense of the experiences, to understand why certain things happened and to establish a 'new self'.

There are three important perspectives I need to acknowledge to readers of this study that may have influenced my thinking and have had a bearing on my role as a researcher. These are that I am a midwife, a mother and a woman. The following is an account of what I bring to the research process in the context of the three perspectives. Initially I had attempted to write this section under the three headings above but as I struggled to do this I came to realise that all three were interrelated and could not be separated out from each other. Consequently my experience of being a mother, woman and midwife are interwoven into one section.

Perspective as a mother, woman and midwife

I have acknowledged in the introductory chapter that I gave birth to my second daughter during the life of this research. I too sustained perineal trauma: an episiotomy with the first birth and a tear with the second. I felt that I could empathise with the women when they talked about their experiences, and sometimes found it difficult not to share my own experiences with them. I was aware that some researchers have shared their professional and personal knowledge with the women they were talking with and for Webb (1984) this caused much anxiety and heart searching as she did not want to exploit the women she was interviewing. Conditions imposed by the ethics committee meant questions could only be posed to participants. However, the women had many questions they wished Webb to answer, as they knew she was a nurse. Webb believed it would have been deceitful if she had used interviews simply as a means of data collection and given back nothing to the women. To use women in this way, by not acknowledging them as an equal gives an impression of a relationship of power between the researcher and the participant. Dominance by the researcher could have an influence on the data that is collected. Webb also believed it was unethical to walk away from the women without addressing their concerns and the women might feel let

down and disappointed. During the time of the study Webb became a 'gynaecology patient' and went through similar experiences that the women were telling her about. This made her feel even more strongly about not wanting to 'take' from the women and give nothing in return. Webb resolved this dilemma by deciding to offer information to women if the opportunity arose during her conversations with them.

I made a conscious decision not to tell the women that I had children of my own unless they asked me the question, as I felt it was important not to distract the women from their story. I was also a novice at 'conducting interviews' and did not want to be in the position of being unable to draw back the conversation to the aim of the research if it went off at a tangent. Re-reading the transcripts shows that I did achieve this.

As a mother of two children I did not find it easy to juggle home life with studying and have often resented spending evenings and weekends working rather than doing 'motherly' things. When I did fulfil my mothering role I often felt guilty about the time spent away from studying. This meant that at times I found it difficult to become immersed in the data and give meaning to it (Glaser and Strauss 1967), having only a short space of time to concentrate before the demands of family life or work took over again. On other occasions when I had spent a period of time away from the studying I was able to approach the work with fresh ideas and found the analysis flowed much easier.

During my practice as a midwife I have become increasingly interested in how women viewed their experience of childbirth. For me this interest developed as I became more politically and culturally aware of the status of women in society and how often their voice was not heard but suppressed by the dominant medical view. An example of such an issue is the challenge women face when wishing to give birth at home. The medically held view is that birthing at home is not a safe option and women should be in a hospital environment to have their baby, despite the lack of evidence to support this. Women's views and wishes are consistently being ignored undermining what they see as the best option in many cases.

My midwifery training in the mid 1980s, took place at a time of transition. Views of women were beginning to be organised into a coherent voice, and they were starting to speak out about a system of care that did not take their views into account. Care was often referred to, as a 'conveyor belt' giving emphasis to the number of people that could be pushed through a system, rather than being an interactive process where quality of care was important. My training took place in a large obstetric hospital, with approximately 6,000 births per annum. I understand now that intervention was common place and the philosophy of care was medically dominated. However, I did share experiences with a number of colleagues who were influential in changing practice by the desire to listen to women. Although I did not immediately embrace their philosophy, I was able to draw on this when I undertook a further course of study, the Advanced Diploma in Midwifery (ADM), three years after qualifying as a midwife. The ADM was underpinned by an enquiring approach to learning. It was during this time that evidence based care was first introduced to me and I began to question many of the practices I had been taught as a student midwife. Language was also important and it was at this time that I questioned my use of the term 'patient' and talked of 'women' instead. I also understood that women birthed their babies and midwives supported them in this process rather than the midwife delivering the baby, implying something being 'done' to them. Although these may seem subtle changes they had a huge impact on how my practice changed to become 'with woman'. My experiences of being with other midwives who had trained and practised throughout the country led me to understand the meaning of woman-centred care. I wanted to embrace this approach when I returned to practise, and share my experiences with colleagues.

Within two years of completing the ADM I qualified as a midwife teacher and was appointed as 'set' tutor to one of the first three-year, pre-registration midwifery programmes (Direct Entry) in the country. The students I shared my knowledge with were all women who had not trained as nurses first, so they were not used to caring for 'sick / ill patients', on a daily basis. Many of them were mature women who were mothers, bringing with them their own life experiences. They were knowledgeable women with much to offer and challenged my thinking on many occasions. These challenges resulted in me reflecting on the student / teacher relationship and led me to compare it with that of the woman / midwife relationship. I tried to approach my

interactions with students with the belief that we all had something to learn, and could share each other's knowledge. Learning is a two way process, a partnership that is interactive rather than a didactic process. I therefore tried to move away from the dominant relationship of the teacher to the student and put us all on equal terms. It was under these circumstances that I learnt to say 'I don't know' to questions I was asked and did not know the answer to.

It was during this time that one of the most influential government reports for many years was published, *Changing Childbirth* (Department of Health 1993). Women-centred care, incorporating choice about what care to receive and control over decision making as well as continuity of care was the focus of this report. The report bought to the forefront the importance of partnerships and relationships when supporting women during childbirth. I strongly believe in these values and it was because of this I took the step to ensure that when writing up my study the women were referred to with pseudonyms and not as a number. I consciously made sure that when writing about the women in my study they were not referred to as 'patients', but again used the term women. I believe this acknowledged their contribution, as women, to my study. I have also tried to ensure that throughout the text I have used the term 'women' rather than 'respondent' or 'subject', both of which imply the passivity of the researcher and an unequal relationship between the researcher and researched (Oakley 1991; Roberts 1990). Sigsworth (1995), in her exploration of feminist research and its relevance to nursing practice acknowledges this partnership approach. Something I would do differently next time is to ask the women to choose a pseudonym rather than choosing it myself. The interviews took place in the privacy of the women's own homes. It was hoped this would provide an opportunity for the women to feel in control of the event and be more relaxed.

My current role as a midwife is with the Nursing and Midwifery Council, the regulatory body for nurses and midwives. While in this role I have been closely involved in reviewing the standards of education and training that leads to an individual becoming a midwife. I have been party to numerous debates about trying to understand the core functions of the role that all midwives would be expected to be competent in at the point they are registered as a midwife with the Council. Defining normality in the

context of the practice of a midwife has been challenging with many of the issues raised being similar to those highlighted in the chapter, 'striving for normality'. Time will tell if clarity has been achieved when the Council publishes the review of pre-registration midwifery education.

I have also been involved in a project that sought to understand how the role of the maternity support worker is able to support the role of the midwife in her daily practice. I have personally found this a challenge, finding it difficult to relinquish aspects of the role of the midwife, which I believe are fundamental to her work. These are often the caring aspects of her role that are now being delegated to the maternity support worker to undertake. For example, supporting women to breast feed, helping women with their hygiene needs after birth and aspects of baby care (NHS Employers 2006). I appreciate that in the current climate of financial deficits and shortage of staff, midwives need to prioritise the care they give, which has resulted in more straight forward care being delegated to others to carry out. I question how fragmented midwifery care will become as tasks are delegated and wonder if this is any different from earlier times when the doctor 'allowed' midwives to undertake certain tasks such as testing urine and weighing women antenatally, before he performed the abdominal palpation.

Perhaps one of the most difficult aspects of the research was not to act as 'a midwife'. There were occasions when I wanted to question the advice given by a midwife and offer the appropriate evidence-base that the midwife should have used when providing care. I knew that this was not my role, unless I believed the advice that had been given would cause harm, based on the Nursing and Midwifery Council's *Code of professional conduct: standards for performance, conduct and ethics* (2004b). This did not happen. I was conscious that any contradiction in advice might undermine the relationship between the women and their midwife, especially as in some cases the women may use the same maternity services and possibly have the same midwife caring for them in future pregnancies. One way of resolving this issue was for me to share any concerns arising from this study with midwives where the research took place, and to talk with the supervisors of midwives at one of their local meetings. In chapter 4 I have explored how women should be facilitated to make a complaint about the care they receive if it is substandard, and that midwives can be crucial to this process. However there are

difficulties if women wish to complain about the midwife who is providing care. It is therefore important that the complaints procedure is transparent within the maternity services, which includes the women's home. In Sarah's situation, I do know that the midwife visiting her in the postnatal period had offered advice regarding the complaints procedure.

In my present job, part of my role is to talk with women who contact the NMC about the standard of care they have received. Many women do not know how to complain to their local trust, reinforcing the notion that this information is not readily available. Often women want an explanation from the midwife or obstetrician about what happened and why, and are looking for an apology. However, from anecdotal experience, because this process is not transparent to the women, the complaint often escalates resulting in midwives being forwarded to the Fitness to Practice Department at the NMC, for investigation.

When listening to the tapes during transcribing, I remember thinking on several occasions that I wished the midwives involved in the care could also be hear what the women were saying on the tape. This was vividly bought home to me when I was listening to Sarah's tape about how she was treated by the Registrar, thinking it would be an important learning tool for midwives in developing their practice and meeting the needs of women. Hall (1997) believes it would be beneficial for midwives to be part of postnatal groups where sharing of experiences takes place. Attending such meetings would enable midwives to hear how women perceive they are treated in labour or their perceptions of issues such as pain and pain relief. Hearing women's stories at these meetings is especially important for midwives, as they are responsible for care of women in normal labour and the most senior person present in approximately 75 percent of all births. As this research has shown, midwives need to be more attentive to the needs of women in the postnatal period and taking the time to really listen to women must be an important step in making the early postnatal period a positive experience.

Learning from the research process

Throughout the study my knowledge and skills as a qualitative researcher have developed. By undertaking the research I have come to understand the process of grounded theory in more detail, which for me as a person who learns best by 'doing', has been the most appropriate way of learning.

If I were to carry out a similar study I would want to devote my efforts to it full-time. It has been difficult over the years to maintain the momentum and enthusiasm to keep going, switching between the 'day job' and studying. Changing employment, away from a university environment where a large library was conveniently situated, and academic debate was a daily occurrence made the whole process even harder. The fact that my job was over 100 miles away from where I lived meant long hours away from home and having to combat tiredness to study late into the evening. I would advise others to consider very carefully before taking up the challenge of undertaking doctorate studies, although the end result has been worth the effort.

One of my first challenges after writing the research proposal for ethics approval, was to write instructions for the diary that gave clarity to the reader about what was being asked. I found it difficult to write the instructions to give a short amount of information whilst using a 'reader-friendly' language not loaded with professional jargon. I was aware that language was important and as Bates (1997) concludes, the language often used by midwives and doctors can be controlling, giving an air of authority and often not understood by individuals not in the profession. Medical words such as perineum were necessary for women to understand the study, so trying to explain where the perineum was and what the study entailed was a challenge. I was also worried about striking the balance between being honest about the topic I was asking women to write about in their diaries, against being too explicit and alarming or worrying women who might wish to take part but could be discouraged if this were not carefully, albeit honestly, described. The perineum is a part of the anatomy that is not usually a topic of conversation and is kept hidden and private, so writing about the perineum to a stranger would not be a usual request women would hear. I need not have worried as the women were very accepting of the topic when approached, possibly because it is an

integral part of the anatomy that is exposed to midwives during a vaginal birth. I thank the women for being so open and honest in what they wrote and what they talked to me about.

I realised early on in my study that it would be important for women to feel comfortable with me asking questions that were quite personal and possibly embarrassing. An article by Paterson (1994) about trust helped me in dealing with this dilemma. Paterson argues that trust may determine the nature of what the women shares with the researcher, so building relationships was important. Part of this trust building in my study was meeting the women before the interview, so they knew who I was. This I managed to do initially when I met them to talk about the study. After the women had given birth I would either go and meet them again in the hospital, or ring them on their return home to remind them about the diary. At this time I also set a date that would be convenient to collect the diary, which I did by going to their home. The women were able to share experiences with me, either through their diary or when talking with me about their experiences, identifying an element of trust existed. The topics shared in these conversations were sometimes quite intimate. Of course, it is never possible to know what else might have been said, and was held back, but certainly much was revealed. For myself, although often nervous about being in an interview situation, I felt very relaxed with the women, listening to what they wanted to tell me. My willingness to listen was portrayed to the women and helped in their conversations with me. I was unsure however, about how much this was to do with sharing common experiences such as being a woman, and them knowing I was a midwife.

One of the main observations arising from transcribing was attributed to my inexperience in conducting the interviews. Reading the early transcripts it is evident that I found it difficult to get the interview underway. I knew I wanted to set the scene and that there were a number of important aspects to address such as saying thank you for taking part, reiterating the issue of confidentiality and reinforcing the notion that they could stop the interview at any time. When I read the transcripts much of what I said seemed muddled. However, I was able to productively learn from this and further

develop my approach and I decided I needed to script an introduction, enabling me to get over the main points coherently and in a timely fashion.

I learnt that listening to what the women had to say, remaining attentive and picking up on cues that needed further exploration required discipline. On more than one occasion I found my concentration waning, usually thinking about how long the interview would take to transcribe. For example towards the end of Janet's interview I was unsure of the relevance of what was being said and frustrated that I would need to transcribe it. Certainly at this point in my research I was beginning to resent the transcribing. However, I was also mindful of the fact that women had graciously given up their time to meet with me and the least I could do was to hear what they had to say. It was important for me to be aware of how I felt, to reflect on it, to enable me to consider this and for it not to interfere with the research process.

I understood early on the medical dominance within research, firstly because of an Ethics Committee's insistence that I must have the Lead Consultant Obstetrician agree to the research and then the need to write to each Consultant Obstetrician asking permission to approach 'their women'. I met with the Lead Consultant Obstetrician for him to agree the research only to be questioned about the size of my sample, the control group and where was my hypothesis. This was an ideal opportunity to educate him about the differences between quantitative and qualitative research and I believe I did a fair job. However, what was more important to me was the permission from the Head of Midwifery as this was invaluable in giving me the opportunity to meet with midwives. Having this support was necessary as it was the midwives who were ultimately the gateway to the women.

I had initially made the decision not to personally approach women to ask them if they would consider taking part in my study. I believed it was important for the midwife who was in contact with the women to make the initial request on my behalf. If the women agreed I would then meet with them to talk about the study. I began to realise how important it was to have the midwife helping in this initial contact. This relationship was highlighted when the midwife left employment and I struggled to find another midwife with the same level of commitment. It became an issue when I had a

gap in the recruitment of women for several months and then I changed my job, working over 100 miles away from where I was trying to recruit women. This further reinforced to me the absolute necessity of having the cooperation of midwives, and effective contact with them when it came to recruiting the women. It was uncomfortable having to rely on others, especially for someone like me, who wants to be organised and be able to plan for when things need to happen. I had to work through a new process of recruiting women and am grateful for the time and effort midwives gave in order to help me. However, it took several attempts to find a workable solution, eventually linking up with two midwives who worked in the community that I could have direct contact with on a regular basis. They would ring me when they had women who were potentially interested in hearing more about the study. I would then telephone the women and explain in more detail what I was doing. This process worked well but I believe the key to its success was the considerable assistance of the two midwives, who were each undertaking a Master's Degree, and had 'inside' knowledge of the importance and frustrations of recruiting women for research purposes. The difficulty I encountered with researching in this context has led me to understand the importance of being able to locate colleagues who are research friendly.

Power was also rightly with the women as they could accept or refuse to take part in the research study. I also experienced a gap in recruitment when a run of women who had agreed to take part gave birth by caesarean section. I realised that when women did not have a vaginal birth I was disappointed and it meant finding another person for my study. I then looked at this from the woman's perspective, realising they were probably disappointed as well. I did not want the women to feel guilty about not being able to take part in my study, so I still went and saw them in the hospital ward and sent them a congratulations card, thanking them for their time and wished them well.

Limitations to the study

The sampling strategy has been discussed in detail in chapter 2, where it was identified that 11 women were recruited to the study, by which time repetition of themes was in evidence and no new ideas were being identified. The diaries and interviews that the

women completed provided rich data for constant comparative analysis to take place. The number of women participating in the study was small but matched the parameters suggested for qualitative research. However, it is acknowledged that this may be viewed as a limitation to the study especially due to the variety of perineal trauma women experienced, that there was a mix of women having their first or subsequent baby and that the births included spontaneous as well as assisted vaginal births.

In my study a small group of fairly homogeneous women were accessed. The women were all of Caucasian origin recruited from one particular part of the South of England in an area that does not have a high multi-ethnic population. The participants also did not appear to be, for example, unsupported, physically or mentally disabled or severely socio-economically deprived. Such women were not purposefully excluded from the study they just happened not to be around when the sampling took place. It is likely that inclusion of a more diverse group of women, such as those with differing ethnic and cultural backgrounds, would lead to further development of the categories. Where women are in contact with a large extended family, other women may have a major influence on preparing younger members of the family for childbirth. In other cases women from ethnic minority groups may be isolated because their family are still in their country of origin. These factors may develop the category 'preparing for the unknown' adding information to how women prepare themselves for the unexpected.

The women participating in the study birthed in one of two maternity units available in the catchment area where the study took place. One unit was a Midwife-led unit and the other a Consultant-led unit, which offered a range of services for both women experiencing a straightforward pregnancy and birth as well as those who have complex medical or obstetric needs. No women in my study birthed at home or accessed a self-employed midwife for their midwifery care, which is a limitation to this study. A broader range of maternity service experience could alter some of the categories such as issues around control if women had birthed at home.

Disabled women may have strong views about their body image due to the negative reactions, prejudices or ignorance of society about how they look and present themselves to the outside world. Disabled women may have had to work hard to

'prove' they are a valuable member of society and have already achieved a level of independence relevant to their specific needs. Involving disabled women in a future study may also add richness to the data and update the categories related to 'concept and significance of control' and 'achieving independence'.

My study may have appealed to a particular group of women who were interested in recording their experiences and were confident about sharing those experiences. They were literate and articulate. Findings may have been different if this study included women who had a history of being abused. My study has identified that for some women, having a perineal tear meant that they blamed themselves for not being in control of events. The position used by many midwives or obstetricians to suture the perineum following a tear, can also cause distress to the women. None of the women in my study openly acknowledged a history of abuse but I cannot say that no women had been / or were being abused. Analysis of data related to 'the experience of being stitched' may also have been different if this group of women were included in my study. Consideration would need to be given about how to recruit women who are known to be abused, so as not to aggravate their situation further, and that the study justifies the need to access such a group of traumatised, and usually difficult group of women to reach. But it would be important to know if midwives are meeting the needs of particular groups of women who are often 'invisible' in the health service system and not necessarily confident in articulating their anxieties.

Diaries were used to collect data over a period of 10 days. This timeframe was set as it is the minimum number of days midwives must be in attendance upon a women in the postnatal period and therefore the analysis of any data collected during this time could have an impact on the way midwives practice. It is acknowledged this is a restricted time frame and collecting data over a longer period of time may have resulted in more or different categories. Achieving 'recovery of self' may have meant something different to the women after six weeks or three months, as opposed to ten days.

Women participating in the study all had babies that were well at birth and did not need immediate or prolonged medical attention requiring separation from its mother. However, in the case of Janet it was known there were concerns that Thomas had an

irregular heart beat and because of this she did express that her needs related more to her baby at times than to the perineal pain and discomfort she was experiencing. A study that explored perineal pain and discomfort in the context of women having their babies cared for in a Neonatal Unit may add or change some of the categories due to changing priorities for women. This knowledge would add to the spectrum of care midwives would offer to women with multiple needs.

Conclusion

I have learnt considerably in undertaking this study. Reflecting on my past experiences I have learnt much about myself, what has influenced my thinking and the way I practice. Completing this study has been a huge challenge and has widened my knowledge immensely in terms of both grounded theory and research evidence in the health profession generally, and more significantly, in midwifery. The women participating in this study have shared much information, which has enabled me to add to the body of midwifery knowledge. Although they have described many experiences, I acknowledge that I will never know what has not been said.

CHAPTER 10
CONCLUSION AND IMPLICATIONS FOR PRACTICE

Conclusion

The aim of my study was to explore the feelings, perceptions and experiences of women in relation to their perineum following childbirth. A grounded theory approach was used for collecting and analysing data from eleven diaries and seven interviews. 'Striving for normality' was identified as the core category. The categories entitled 'preparing for the unknown', 'experiencing the unexpected', 'adjusting to the reality', 'getting back to normal' and 'recovery of self', contributed to the framework (appendix 12).

The intensity of perineal pain and discomfort women experienced was generally unexpected and had not been prepared for. Pain is not a normal sensation and is often only experienced during periods of illness. It is because of the perineal pain and discomfort and its subsequent effects on body function and daily activities that women expressed a need to get better. Women saw the postnatal period as a time of recovery to get back to a perceived normality. Normality in this context meant doing normal things and feeling like their normal selves.

Several steps were necessary for the women to achieve as they moved through their journey of recovery. Firstly there was a need to manage the perineal pain and discomfort in order for body functions to be carried out as comfortably as possible. The next steps involved moving from being dependent on others for help in carrying out activities to managing more independently and requiring less help. The final step was to regain their familiar body. The pathway of recovery that women described has similarities with Maslow's lower order, hierarchy of needs and forms the framework that underpins the findings of this study (appendix 13).

The perspectives of the participants depended on the social conditions, previous experiences, the process of their pregnancy and the prior assumptions that they held. A

distinction was identified between experiences for those women expecting their first baby and women expecting their second or subsequent baby. For many women expecting their first baby, childbirth is an unknown experience and often their expectations do not match the reality of what happens. Women having their second or subsequent baby draw on previous experience to prepare them for the perineal pain and discomfort following birth.

The main theoretical idea that emerged from this study and derived directly from the data is that:

> If women are able to successfully adjust to their new and often unexpected reality after the birth of their baby, and begin to reclaim their selves and their world, then they experience a return to their normality.

In this chapter I will explore the theoretical ideas that developed as well as describing the implications for midwifery practice and education that arise directly from my research. Suggestions for future research are also included. This chapter therefore demonstrates how my research has made a contribution to knowledge in this field

Contribution to knowledge

Despite the high incidence of perineal trauma sustained by women during childbirth, there is little research that takes into account the views and experiences of women about their perineum following birth. My research resulted in the emergence of perspectives from a group of women of a phenomenon that has not previously been examined or fully recognised. These perspectives will contribute to midwives' understanding of perineal trauma by providing insight into the experience women have of their perineum following childbirth.

The intensity of perineal pain and discomfort for women in my study having their first baby was unexpected. Despite attending antenatal preparation classes where the women acknowledged this was discussed, it was seen as irrelevant information for the

women at the time. The findings from my study recommend that the timing of when the effects of perineal pain and discomfort are discussed commence in the immediate postnatal period. This is a change from current practice.

Women viewed the early postnatal days as a time of recovery, which challenges the view, held by many midwives, that childbirth is a normal event. Recovery is a term often used following a period of illness. A number of findings from my study suggest women do not always experience the postnatal period as a time of wellbeing. Women expressed a desire to return to normal, implying that an event had occurred that they needed to recover from. Examples of events included needing help with initial personal hygiene care when an epidural has been used for pain relief during labour, the experience of perineal pain, and moving from a state of being dependent to one of independence and altered body image. This raises the question about whose definition of 'normality' is being used when midwives provide care to women and whether midwives and women share the same reference point. This had not previously been explored and my results can be used as evidence to support practice. An example of where practice can be developed by understanding normality from the perspective of women is with the assessment of perineal pain and discomfort. Even though women may have experienced a 'normal' birth women may not view the resulting perineal pain and discomfort as a normal consequence. Midwives must therefore not trivialise the amount of pain experienced because from their perspective this may be normal.

Conclusions are presented from analysing data collected from asking women to keep a diary for 10 days following the birth of their baby as well as a follow-up interview within two weeks of collecting the diary. In the diary women recorded their thoughts and feelings about how their birth canal and surrounding area felt when carrying out daily living activities. Daily living activities were described as tasks such as walking, sitting, eating, sleeping as well as caring for their baby. Women were asked to describe if the activities were affected in any way by the birth and if they had to make any adjustments to the way they cared for themselves and their baby. A follow up interview provided the opportunity to explore the content of the diary in more depth. Diary and follow up interview, known as 'diary: diary-interview', (see chapter 2) has not been fully recognised in the midwifery profession as a means of collecting data for

research purposes. In my study it has proved to be a useful approach in meeting the aims of the study. The advantages of collecting data in this way has been that women can initially record information at the time it happens, rather than having to rely on recall at a future date, and the interview provides an opportunity to explore the diary entries in more depth. The diary: diary-interview facilitated women to tell their stories from a perspective that was important to them as well as adding to the information collected from the diary by using interviews. This approach to collecting data would be useful to consider when seeking a more profound understanding of the experience of individuals in other health care arenas. Although the approach is not new, it had not been readily used in this context.

Previous studies about effects of perineal trauma have not normally included women with intact perinea, instead concentrating more on women who sustain perineal tears or require an episiotomy. Involving only the latter groups of women denies those who have an intact perineum a voice to share their experience of how stretching, bruising and swelling of the birth canal and surrounding area can also have an impact on daily living activities. My study was inclusive of these women contributing to a different perspective to the body of available knowledge.

Implications for practice

My study identified midwives need to realistically prepare women having their first baby for the consequences of perineal pain and discomfort after the birth. In order to do this midwives need to understand perineal pain and discomfort in the context of the experience of women and how it impacts on their return to a perceived normality rather than falsely assuming from a knowledge base that appears to lack relevance to the real experience of women.

Women being unprepared for the reality of perineal pain and discomfort in the postnatal period is not a new finding, but in spite of innovation, new thinking and efforts to change practice, women still have problems being prepared for the actual experience, which often remains unexpected. The continued lack of preparation raises

the question why this is still an issue for women, especially where opportunities for change have been made available with government policies such as *Changing Childbirth* (Department of Health 1993) and more recently *National Service Framework for children, young people and maternity services* (Department of Health 2004), supporting women centred care in order to meet the individual needs of women.

One reason for the lack of preparation found in my study is that women having their first baby are selective about the information they take notice of and is dependent on what they imagine will happen after the birth rather than on the reality as communicated by others. Women who attended preparation classes during pregnancy remember that information was given about episiotomy and perineal pain, but by their own admission did not listen attentively because it was not relevant to their immediate needs. Suggesting to women having their first baby that they are likely to experience perineal pain after the birth is not helpful as the main focus for women at this time relates to their pending labour and birth.

As the consequences of birth are unknown until after the event it is difficult for women to fully appreciate what information would be of value to them until it becomes applicable. If women are not ready for this information until the outcome of birth is known then support and information sharing about perineal pain and discomfort and its impact on bodily functions and daily living in the postnatal period becomes an important aspect of postnatal care as opposed to antenatal care as is current practice. Women need to be supported appropriately, at a time when the reality of what they actually experience becomes evident. Therefore midwives need to find a workable solution, where realism is combined with appropriate timing, which would mean taking a different approach to what, and how, care is provided for in the postnatal period.

My study has identified that the postnatal period is a more appropriate time to begin to address, in any depth, the consequences of perineal trauma. Discussions could ideally start around the time the perineum is being sutured. This must be balanced against the individual needs of women, as early information may not suit everyone. It would be important for midwives to assess the needs of women and make a judgement with them about how much or how little any information would be useful to discuss. For example

women who have had a long and difficult labour may not be receptive to new information this early on, where the baby is unwell and has to be apart from its mother for a period of time after the birth. An acknowledged limitation to my study is that the women who participated all had babies that were well at the birth and did not need immediate medical intervention or required to be separated from their mother. However, in the case of Janet it was known there were concerns that Thomas had an irregular heart beat and because of this she did express that her needs related more to her baby at times than to the perineal pain and discomfort she was experiencing (see chapter 6)

Many midwives have the knowledge and skills to suture the perineum and it is usual for the midwife present at the birth to carry out the procedure if required. Midwives therefore have first hand knowledge of the extent of any trauma as well as any particular circumstances that may have caused the trauma to happen. Relaying this factual information to women can help them come to terms with why their perineum tore so reducing the likelihood of blaming themselves for not being 'in control'. An example of this type of information would be if the perineum was intact at the birth of the baby's head, but was torn as the shoulders emerged over the perineum. An example in my study was that it was explained to Brenda that the cause of the grazes to her labia was due to baby's hand emerging over the perineum at the same time at its head.

Examples of information midwives need to discuss early on after the birth should include therefore what to expect when passing urine for the first time or how to lie in bed comfortably while cuddling their baby. Time could also be spent talking about ways to initially manage the pain that will be experienced, which would include ensuring the appropriate type and strength of analgesics are prescribed by the doctor, or supplied by the midwife, before women are transferred to the postnatal ward if they gave birth in the hospital. Revisiting the women at an early point to assess what the women had understood would be important to provide a baseline to know what needed to be reiterated or re-explained. Janet is an example of the importance of timing and potential repetition as she explained that the only thing she could concentrate on while having her perineum sutured was when she would be allowed to cuddle Thomas.

Having this close liaison between women and midwives in the postnatal period is not always easy to fulfil, especially at a time when there is a shortage of midwives, many women returning home between 6 to 24 hours of birthing and care being frequently delegated to others, such as the maternity support worker. An example of this is readily seen in helping women with their initial personal hygiene care. I would argue that this early time after the birth is another opportunity to educate women about a variety of issues related to perineal care and pain management. In this context, personal hygiene care becomes more than a physical task that can be delegated, but an important role for midwives to personally undertake. It is an early means by which the midwife can explain to women what to initially expect now the outcome of the birth is known. For the midwife to continue to undertake this role would mean a move away from the more common approach where maternity support workers for instance, are delegated the task to complete. There may be several reasons for using maternity support workers in this way, for example midwives believing initial hygiene care for women is not as important as other aspects of their role, so can easily be delegated to someone else. The results of my study lead me to argue that this is not the case, that this is a crucial task.

However, delegating allows increased time for midwives to complete what they perceive as more essential aspects of their role such as record keeping. With the pressures of a busy delivery suite there is often the need to transfer women to the postnatal ward as quickly as possible in order to have a room 'ready' for the next woman attending in labour. To manage this it is necessary for tasks to be carried out simultaneously so record keeping by midwives can be completed while maternity support workers are helping women with initial hygiene care. Similarly the maternity support worker may help women to wash in bed, if they are unable to walk as a result of the effects of an epidural, and at the same time the midwife would wash the baby.

This approach although apparently a good use of resources in theory is not so in practice as women may be distracted during their wash from watching, or even taking part in their baby's first wash. It may be the first time that they see the baby naked if it has been wrapped in dry towels up until this point. This is a special time for the parents and should have the least amount of distractions possible. Conversely, a different

approach often takes place when women birth in the home where it would not be unusual for midwives to offer help when women shower or use the bath, albeit many women manage this on their own due to having had a normal birth.

Although maternity support workers are assessed as competent to perform the task and many would do so to a high standard, they do not have the underpinning knowledge about perineal trauma and the individualised information that would be appropriate to talk to women about. Midwives would still need to find time to discuss with women perineal care. Therefore in the long term using the maternity support worker at this point may not save time or free up midwives to provide other aspects of care although it appears to do so. Using maternity support workers for hygiene care reinforces the evidence discussed in chapter 9 that junior members of staff usually undertake tasks related to bodily functions. The first few hours following birth is crucial for midwives to use the time effectively and to use it for emotional support and information giving. As a result of my study I would encourage midwives to question if delegating personal hygiene needs to junior members of staff is the correct use of delegation and is not compromising care of women and undermining their own role.

Discussions at the time of suturing and washing could be reinforced by a small, user friendly leaflet that focuses on types of pain and how best to manage perineal pain and discomfort. This approach would enable women to recognise they were not alone in their experience and that although they may not have expected it, it is common. A leaflet also enables women to look up information when it is convenient to them, rather than having to wait for a midwife to approach them as anecdotal experience suggest that women do not like to 'bother' the midwife, as they are busy people. Factors related to the leaflet being user-friendly include being free of complex medical jargon and concise with pictures or cartoons to illustrate a point. The leaflet would also inform women what they can expect from the midwife in terms of pain relief, as well as suggestions from an evidence-base about what other women have found helpful. This should not be used as a substitute for talking with women, but compliment it. It is appreciated there are limitations to this approach not least for women who do not read, or where English is not their first language. The cost of setting up such a scheme may also be prohibitive, but innovative ways of securing resources should be explored. The

introduction of any leaflet would need to be evaluated for its effectiveness, which should include style and readability. It would be important to involve women, user groups and organisations such as the Maternity Services Liaison Committee in developing any information leaflet to help ensure its usefulness. Women and user groups being involved in such a development would also help to ensure where the local population had specific needs such as multiple languages, this would be addressed. Midwives would need to remember also that providing leaflets are not suitable for everyone, so should not be the only medium by which this information is available.

The role of the midwife has been discussed and identifies a lack of clarity concerning where the boundaries are in relation to the core work of midwives. If the boundaries of the role of the midwife can be clearly articulated then the delegation of tasks to others becomes clearer and more consistent across the maternity services. The regulation of the role of the midwife lies with the regulatory body, the Nursing and Midwifery Council and is a debate that needs to take place within the profession taking into account what is safe for women and what women want. There are an increasing number of external factors that have been discussed in my study, which are applying pressure on the type of work midwives undertake, extending her role in many areas often related to the use of technology. This expansion in role is happening at the expense of remaining skilled in the art of normality without the clear evidence that it is of benefit to the women or their babies. The result is that care seen to be unnecessary or not important for the midwife to undertake is being delegated. Until the profession debates these issues confusion will continue about what is 'normality' and within whose domain the delivery of 'normal' care rests. As midwives extend their role in skills that were once the domain of the obstetrician without justifiable benefit to the women or their babies, delegating tasks can fragment care and move away from an approach than holistically meets the needs of women. The result is that care continues to be routinised reinforcing the medical model of care.

The descriptions women gave of having their perineum sutured were mixed depending whether this was their first or subsequent experience. It was identified in my study that for women having their first baby, the experience of their perineum being sutured was often traumatic. There were a number of reasons for this including inadequate pain

relief, finding the lithotomy position distressing and the length of time it takes for the procedure to be completed. These findings, like being unprepared for the consequences of birth, are not new and for some women remain a traumatic experience. It is unclear from my study or the literature why the disturbing experiences women recount still happen. Attempts have been made to educate midwives that the use of the lithotomy position is not always appropriate and other ways of ensuring a clear view of the perineum could be utilised. In support of this it is likely that the guidelines on intrapartum care by the National Institute for Health and Clinical Excellence will recommend lithotomy position is not necessary for all perineal suturing.

The length of time the procedure takes is difficult to control for and most likely dependent on the degree of trauma needing to be sutured or the skill of the operator. Inadequate pain relief is inexcusable but one argument for this happening is midwives wishing to maintain the birth experience within their domain. Midwives, under legislative direction, are only able to use a prescribed amount of local analgesia to numb the perineum. Once the maximum amount has been used, further or stronger doses would have to be prescribed by obstetricians, or more likely, a completely different sort of method to numb the area would be used. Other methods would be a pudendal block that is only performed by obstetricians, where local anaesthetic via a transvaginal route is injected directly into the area around the pudendal nerve. To access this nerve the needle has to penetrate deep into the perineal muscle. This procedure has similarities to the injection that the dentist would administer into the gum of the mouth before doing a filling on a tooth for example. An epidural or spinal (injecting local anaesthetic into the subarachnoid space directly into the cerebrospinal fluid) may be needed instead and anaesthetists only do this procedure, so again has medical involvement. Asking for obstetric help may be seen as an inconvenience for midwives and so avoided. Some midwives may see using obstetricians or anaesthetists in this way, as turning what was essentially a normal outcome, into one that now needs medical intervention. However, if more local analgesia is required then the amount of trauma should be questioned and whether the midwife is working outside of her scope of practice and that the obstetrician should be undertaking the procedure. Further exploration would be useful to understand if midwives do appropriately refer women to

the obstetrician for perineal suturing, or whether there are other reasons why adequate pain relief is not always achieved for the procedure.

Although it has been discussed that obstetricians should be involved if the local anaesthetic being used is not adequate, evidence from my study identifies obstetricians do not get it right either. Sarah's description of the attitude of the obstetrician is concerning and raises many questions about how this was allowed to happen and where was the midwife who should have been acting as an advocate, for her. It is the experiences that participants expressed in their own words on tape which led me to wish that midwives involved in the care could hear what was being said. Feedback from women enables health care professionals to have insight into how their practice is perceived and is therefore an important part of learning and improving care. In circumstances such as Sarah describes, women need to be helped much more about how to give feedback, and any complaints procedures ensure their issues are heard.

In order for midwives to be aware of what women are saying about the care they are receiving it is important to ensure the findings of this study are disseminated to a wide audience. This means that journals readily used by midwives need to be considered when preparing the material for publication as well as forums where midwives meet either locally or nationally to debate maternity issues. As identified in this study midwives do not necessarily understand research evidence partly due to the way it is presented. The challenge is to ensure that information is easily understood, which needs to be taken into account when choosing which journals to target and a range of both professional and academic should be considered. This study is about women so sharing the findings with a lay audience is also important and there are a variety of forums where this information could be disseminated to achieve that aim.

Women having a second or subsequent baby used their previous experiences to prepare them for the postnatal period. In these instances midwives had little input in guiding women in their preparations. In view of this it would be useful for midwives to evaluate their role regarding what information women find helpful and how best to make it available to them. Rather than information about birth and the postnatal period it may be more relevant for women to initially share and explore their previous

experience of birth and then use this as a foundation to build on the information they would find helpful. Depending on the needs of women this may be done on an individual basis or as a group discussion, but would need to be skilfully facilitated to ensure everyone who wishes to participate is given the opportunity. Midwives must ensure they do 'no harm' and if women are identified as having unresolved issues then the appropriate support networks need to be in place to refer the women to, such as a counsellor. This approach of listening to women can be alien to midwives when many are working in a culture that is dominated by 'doing', especially where routine practices are carried out that may not be meeting the individuals needs of women. Competence in the use of listening skills and facilitating groups with diverse needs should be an integral part of the initial education of midwives. This proposal (and others) has recently been debated at the Nursing and Midwifery Council to ensure midwives are competent at the point of registration in the relevant skills required for contemporary practice (Nursing and Midwifery Council 2006).

Women in my study having their second or subsequent baby were pleasantly surprised if their perineum did not need stitches or if it did, the experience was reported as being much better that before. This was partly due to the type and amount of trauma being different on the second occasion, such as in Anne's case from an episiotomy first time, to a first degree tear following the birth of her second child. It was not the remit of this study to compare perineal trauma with subsequent births but what is important to note is that women still had vivid memories of their previous experience. Midwives need to be aware of this, as there are implications about how this could be explored as part of their role. Women should be asked soon after having their perineum sutures, what their thoughts and feeling were about the experience. Midwives who undertook the procedure would be best placed to discuss these issues directly with the women, as they would be aware of the detail of the procedure pertaining to the particular woman and be able to answer any questions or queries immediately. It would also be an opportunity for midwives to reflect on their own practice and audit the outcomes.

Similarities and differences between perineal pain and the pain of labour have been explored in my study. Both types of pain are unfamiliar and beyond the everyday experience of women. However women looked upon perineal pain differently from the

pain they had prepared for and expected in labour. Techniques and coping strategies to manage the pain in labour are taught to pregnant women attending birth preparation classes, where the pain is interpreted as' positive' and 'purposeful'. In contrast pain caused by tissue damage as in the case of perineal trauma, triggered an illness response in women and it is within this context they described their perineal pain and discomfort in the postnatal period. The shift of pain being experienced from the perspective of wellbeing, to pain being experienced from the perspective of ill health makes defining the postnatal period in the context on 'wellness' difficult for women. Women describe a period of recovery and wanting to return to normal, which reinforces the medical model of childbirth. The majority of women giving birth today are fit and healthy. The sudden experience of perineal pain, the intensity of which they are unprepared for, does little to help women cope with the shock of finding they are unable to carry out activities as easily as they would have normally done. The impact pain and discomfort has on women carrying out routine activities signals the loss of a familiar body that needs time for recovery in order to return to normal. It is this sudden change to experiencing pain and becoming dependent on help that influences women's perception of the postnatal period being a time of recovery rather than a period of normality.

It has been shown that women describe pain differently depending on its location and intensity. As the experience of pain is individual to each woman, pain management should not be routinised, which would mean a move away from the medical model of care. Assessment of pain should be an integral part of postnatal care with women being involved in determining the amount of pain they are experiencing. The assessment of pain is not consistent and women continue to experience perineal pain and discomfort. Pain assessment scores are widely used in nursing following surgery or for chronic pain management. There would be merit for midwives to review this approach and determine if any of the scoring systems can be used for women in the postnatal period to ensure women are receiving appropriate and adequate pain relief. Chapter 4 highlights the use of pain assessment scores and demonstrates their advantage in providing a method to record the type and intensity of pain, which is helpful when different midwives see many women over a short period of time. Continuity of carer (the midwife) in the postnatal period is important to enable midwives to assess the consequences of any perineal trauma from an evidence-base of knowing the women

before hand. Discussion would continue with the women, finding out how they were coping, what was working well and what needed adjusting. This would reduce the need for women to explain again to a different midwife or midwives what the issues are. Although continuity of carer is ideal many maternity services do not provide this model of care. Having a means of recording the subjective experience of pain is a compromise and can only help women in their quest to ensure effective pain relief.

Pain and discomfort following birth hindered women in undertaking activities that would normally be done without a second thought, such as passing urine, walking and sitting. The lack of ability to carry out these functions without pain was debilitating for the women and focussed much of their attention. Pain management should therefore include not just pain relieving drugs but also strategies to help improve mobility, how to sit comfortably and what to expect when passing urine for example. These strategies may already be part of the midwives repertoire of information giving but the timing of when this happens merits further consideration. If information is given during pregnancy it needs to be reinforced during the early postnatal period as it has been shown in my study women are not always receptive to issues related to the perineum in the antenatal period.

My study has highlighted that appropriate pain relief is important for women in order to continue with their daily living. The midwife has an important role in being able to assess with the women the amount of pain being experienced. There are implications for the initial training of midwives to ensure competence in this area, as my study identifies a gap in the knowledge and skills of midwives. For midwives in practice this is also an issue and if pain assessment scores were found to be effective for women in the postnatal period, then further education and training would be required for this group of health professionals.

Women who see the same midwife consistently, or a small group of midwives is a model of care recognised by many in the midwifery profession as the preferred option to meet the individual needs of women and is supported by government policy. An argument for not embracing this model, is related to the competition within maternity services for scarce resources and postnatal care has traditionally been seen as the

service to divert resources from when funding is limited (Audit Commission 1997). Maternity services, where this model has been successful have had to revert back to a more traditional approach to care due to shortage of midwives and lack of funding. This had led to midwife-led units and birthing centres around the country closing in order to redirect resources back into the acute NHS Trusts. The resources that are freed up do not necessarily mean it is used within the maternity services, but put into a general pool to help cancel the Trust debt.

The initial impact of childbirth on the perineum and surrounding area meant that in the first few days, women largely concentrated on managing the effects of this. Chapter 7 discusses that the impact went beyond the immediacy of coping with bodily functions extending into other daily activities in terms of managing and completing them. This means the underpinning philosophy of care for the postnatal period should encapsulate a holistic approach, where physical symptoms are not tackled in isolation to the psychosocial impact the pain may also have. Defining pain related to physical symptoms only promotes a medical model of childbirth and is at odds with viewing childbirth as a physiological process. The medical model promotes perineal pain as a single entity rather than part of a whole and understanding it in the context of the birth story. This would mean incorporating any social and psychological impact it might have rather than just dealing with the pain. This would enhance midwives understanding of what women are meaning when they say they are striving for normality so being better able to support them meeting their goal.

Using a holistic model of care does have implications for practice, some of which have already been discussed. In order to understand how the birth experience is effecting women from a social, psychological and physical perspective, midwives would need to meet the same women during both their pregnancy and postnatal period, and for reasons discussed above, during the birth would also be of benefit. This would help midwives to build up a relationship with the women and begin to understand what is important from their perspective. With women getting to know their midwife, discussions can build over time rather than having to start from scratch each time a new midwife arrives to provide care. With this model of care, maternity support workers would be part of a team also getting to know a small group of women. If maternity

support workers are then delegated tasks within a team framework, it would help prevent care becoming fragmented, enhancing the impact of holistic care.

Although the number of women recruited to my study is small, distinct differences were noted in how they dealt with the outcome of the birth. This depended on whether 'control' was an important part of their life style or being more philosophical in their outlook, believing 'what would happen would happen'. If midwives got to know women well during pregnancy, it could be argued that predicting some of the likely reactions to the consequences of the birth in the postnatal period may be possible. Antenatal care should therefore include being with the women and listening to their hopes and fears in order to help understand how best to support them in the postnatal period and not be just about performing routine observation to assess the progress of pregnancy. This moves away from the traditional giving out of leaflets at the beginning of pregnancy for women to take home and read, but encourages midwives to engage in dialogue with the women about meeting their individual needs. Although leaflets can be a useful means to reinforce information, such as discussed with the leaflet describing different types of postnatal pain, there is a need for them to be used at the right time. Understanding personality and psychological theories of control would be an important part of midwives initial education in order to help women approach birth and afterwards according to their general lifestyle and known coping strategies.

This study demonstrates how in many respects body image is significant to these women at this point in their lives from how women express their difficulty with walking to imagining the worst of their perineal injury. A sense of well being is achieved when all the components that make up body image are balanced, that is body ideal, body reality and body presentation. It has been discussed that if there is failure in any one of the components then an altered body image may result incorporating similar feelings to that of ill health. This is important for midwives to appreciate in order to understand women's progress in returning to normal and that altered body image maybe another reason why women refer to the postnatal period as a time of recovery. Midwives do not assess altered body image in respect of perineal trauma. If done at all it would happen during pregnancy where some women may have difficulty in accepting their changing body shape as the pregnancy progresses. Midwives are uniquely placed

to help women in re-establishing a satisfactory body image in the postnatal period. Body image appears a complex phenomenon comprising of a number of aspects, dramatically affecting the perception women have of themselves. This in turn may affect the way women come to terms with their perineal trauma and recovery in the postpartum period. There is lack of information at present to aid understanding in how women perceive their perineal trauma in relation to body image and how closely aligned their body ideal is to their body reality. Midwives are in an ideal situation to help women understand potential reactions that may occur following the birth of their baby. Midwives can help explore strategies to assist women in understanding their reactions and find ways of coping with the situation. This would be new work for many midwives but would have advantage for women in helping predict reactions and therefore having the potential for managing those reactions with any perineal trauma they may sustain.

It is evident from the experiences women describe that midwives do not always practice from an evidence base, some of which has been available for several years. This has implications for how midwives are educated in their initial training programme as well as how midwives are kept up-to-date once qualified. Students have been educated to a minimum of diploma level since the late 1980s and many have qualified at an academic level of degree. Despite therefore many midwives having an understanding of research evidence, practice is slow to change. There needs to be a culture that embraces practice development and management of change in the practice environment. Students learning about these issues in order to utilise the skills appropriately once qualified can enhance this. Learning alongside other professions such as obstetricians can also help in developing respect for each others profession, promoting and environment of being able to work together for the benefit of women and their babies.

Suggestions for further research

The women recruited to my study identified that they were not receptive to information during the antenatal period that they perceived as irrelevant. I have suggested it may be

more helpful to women to receive this information at a time when they are able to absorb and use this, such as in the early postnatal period. Further research would be appropriate therefore to determine if such a change in timing regarding the provision of information about perineal pain and discomfort until the early postnatal period meets the needs of women. It would also be helpful to research further into what information women actually regard as important to receive about managing perineal pain and discomfort in the first few hours after birth.

My study commences at the beginning of a process of returning to normality following the birth of a baby but only provides insight into the first 10 days following birth. Further research in the form of a longitudinal study would provide information that could be used for the development of services in respect of the support women require in the longer term to either enable them to meet their goal of returning to normality enable them to redefine it into something else.

Abused women or those in an abusive relationship were not knowingly recruited to the study and their experiences may have been different as they tried to manage what they could perceive as a further 'assault' on their perineum. Replicating this study with a different group of women would provide further insight into women's perception of their perineum following childbirth and consequently further evidence of different types of support women may find helpful in the postnatal period.

Altered body image as it relates to perineal changes is not something that is commonly assessed in midwifery. Further investigation in this area could help determine if it is an effective tool to help women come to terms with perineal trauma.

Birth is a life-changing event and the care given to women has the potential to affect them both physically and emotionally. In conclusion women's experiences of their perineum following childbirth do not match their expectations and can blight an early return to a desired normality. As a result women need a period of time to recover from the events of giving birth. My study has concentrated on the perineum following birth and offers a number of recommendations to improve the experience for women. The

challenge now is treat the cause rather than the symptoms and to identify best practice for maintaining an intact perineum.

> *"I can't believe God made such a perfect process for birth and forgot to make the opening large enough to get the baby out without a tear. There must be a way."*
> Tritten 1987

APPENDIX 1

THE STRUCTURE AND FUNCTIONS OF THE PELVIC FLOOR, VAGINA AND PERINEUM

Pelvic floor

Attached to the bony circumference of the pelvic floor outlet are two layers of muscles, which are slung like a hammock, providing a 'floor' to the bony pelvis. These are collectively called the pelvic floor muscles and are often described as being in two layers, the deep muscle and the superficial muscle. The deep layer is composed of three pairs of muscles (pubococcygeus, iliococcygeus and ischiococcygeus) arising anteriorly and laterally passing posteriorly and medially to meet the identical, and opposite muscle in the midline. These three muscle layers are often considered to be three parts of a whole muscle called the levator ani.

Below the lavator ani muscle, and therefore more superficial, are three pairs of muscle (ischiocavernosus, bulbocanvernosus and transverse perinei) plus the sphincter muscle of the anus, and the sphincter muscle of the urethra. These muscles make up the superficial muscle of the pelvic floor.

Surrounding and connecting the superficial and deep layers of muscles are 'packing materials' known as pelvic fascia and loose areola tissue. Anteriorly, a triangular piece of fascia connects the right and left ischiocavernosi and transverse perinei, and is sometimes called the urogenital diaphragm or triangular ligament.

Perineal body

The perineal body is a wedge shaped muscle and fibrous tissue situated between the vagina and the rectum. It is an integral part of the pelvic floor being the central point where both the levator ani and most of the superficial muscle unite. The top of the wedge is formed from the fibres of the perinei muscles, along with the bulbocavernosus in front and the external anal sphincter behind. The functions of the perineal body are to assist in the process of birth and defaecation.

All the muscles of the pelvic floor take their sensory and motor nerve supply from the branch of the pudendal nerve. This arises from the spinal column at the position between the second sacral bone and the fourth sacral bone of the spinal column (S2-S4). The blood supply to the muscles of the pelvic floor arises from branches of the internal iliac artery.

One of the functions of the pelvic floor is to support the weight of the abdominal muscles and pelvic organs. Its muscles are responsible for the voluntary control of micturition and defaecation and play an important part in sexual intercourse. During childbirth it influences the passive movements of the fetus through the birth canal and relaxes to allow the fetus to emerge.

Perineum

Hay-Smith (1993) identifies the 'true perineum' in the literature review for her study related to postnatal dyspareunea (painful intercourse) as diamond-shaped and described in relation to bony parts of the pelvis. It is the area below the pelvic outlet bounded anteriorly by the pubic symphysis, laterally by the ischial tuberosities and posteriorly by the coccyx. In much of the obstetric and gynaecology literature however, the perineum is referred to as an area between the introitus and anus and known as the 'obstetric' perineum. For the purpose of this study the perineum is referred to as the 'obstetric' perineum.

APPENDIX 2

DIARY TRANSCRIPT - GEORGINA

Day 1
Baby was born at 7.45am. I was lucky enough only get a small tear that required no stitches.
Even so the area is swollen and feels delicate so I walk slowly and get on and off the bed gently so as not to stretch it.
I had applied Calendula cream on the area for two weeks prior to the birth hoping it would reduce tearing.

Day 2
The whole area feels much relieved by using the bidet or shower, then dry pads several times a day.
It is sore to dry though so I pat with a tissue.
I am drinking pineapple juice to help reduce swelling and pure juice to soften any motion so as not to strain when I do go.
I feel I would like the area back to normal so I have started my pelvic floor exercises, several times a day.

Day 3
The feeling is returning to the area, which is swollen and quite tender, but not painful.
I was able to pass a motion without feeling the need to hold a pad on the area as I have before when I had stitches.
I am doing the pelvic floor exercises several times a day to help the area.
It felt very heavy in the afternoon so I tried to rest.

Day 4
The swelling has gone down a lot today, still feels sore though.
It helps a lot to put the shower on the area and pat dry.
I go home today, so feeling a bit delicate will stop me rushing about.

Day 5
As long as I take it easy I got on with most jobs at home and even went for a short walk.
The area felt a little heavy and it tugged a little when climbing stairs.

Day 6
I went for a walk for 15 mins, taking it easy, but found I was holding my breath a bit.
I feel aware of the tenderness of the muscles needed to push out baby.
Later I passed a large clot (egg size) and increased blood loss.
(I rang the Maternity Unit).
It all feels heavy.

Day 7
It feels much less heavy today especially after a good sleep.
Bleeding not so bad, but I stayed in and took it easy.
The swelling and tenderness has nearly gone.

Day 8
I went for a short walk my pelvic floor feeling tender still.
The small tear has healed, but has left a little piece protruding.
I hope it isn't a problem later.
The bleeding seems to resume after a walk and it makes me feel a little tired.

Day 9
Everything feels nearly back to normal until I go out and I find I am walking quite gingerly and slowly.
At least the bleeding has stopped.
The only things I have avoided is lifting the baby bath and hoovering at the moment.

Day 10
Everything feels much more normal now.
I got in the car without being too slow and walking too.
My womb has gone back and the bleeding has stopped.
The area feels much recovered just slightly tender, so I am gentle when wiping or drying.

APPENDIX 3

INTERVIEW TRANSCRIPT - SARAH

DATE: 22 March 2004
SW. Susan Way S - Sarah James – baby Paul - husband

SW. I'll leave that going for now, but what I would like to say is if at any time you would like to give this up, you know if you have something else you want to do, or he doesn't settle, we'll just call it to holt – it doesn't matter. It's not a problem…

S Right

SW I just want to talk very briefly about why I am doing the research, if you don't remember, and to thank you for having me back in your house, having done the diary.

S Do you want me to turn the radio off, it might be easier?

SW If you want. (tape turned off for a few minutes while radio turned off and Sarah gets comfortable again).
It's really helpful you having agreed for me to do this, for me to come here and have this agreed to be interviewed. The tape is only listened to by me, and I transcribe it, so nobody hears anything on it. And it helpful that you have agreed to it being taped. The main reason behind this research is really so that I get an understanding of what it means to women to have babies, and bruising and swelling and what all that means – if anything

S (laughs)

SW But to come back and interview is to really pick up some of the things you have written in the diary, so that I understand what I think you are saying in it. And then you can expand on that and tell me other things you might have remembered. So hopefully this will be more of a chat rather than me asking loads of questions. We'll just follow through on some of your ideas and I will ask anything. So to start with, I don't know if you can remember much of what is written in your diary? But it is just going back to when James was born and you've written very early on that you needed to have an episiotomy which meant stitches

S Mm

SW When they first told you that, had you thought that was how things were going to happen? Or was it a bit of a shock?

S No, because I had actually planned on a water birth…

SW Right

S …and was quite adamant that it was going to happen. Actually I think from the word go I was quite confident that I could deliver in the water. I don't know why (laughs) and because they didn't actually tell me they were going to do an episiotomy, I think I wrote in the diary that the Registrar was a little bit backward in coming forward…

SW Yeah

S …in the information about what she was and wasn't going to do…

SW Yeah

S …(um) the whole conversation I had with her was mainly around having forceps(becomes very tearful)

SW Are you sure you are alright talking about this?

S Yeah I', alright, I always get like this, (um) because the conversation I had with her was do you want me to deliver the baby with forceps? She was quite brash, (um) and when I agreed to having forceps, it hadn't occurred to me at that point, although I did know that forceps meant an episiotomy. (pause), I'm crying now (said very quietly, wiping away tears). This is quite normal for me, don't worry…

SW Ok, alright

S …it wasn't until I was laid there and she was getting all the forceps stuff ready

SW Right

S That I realised it was going to involve and episiotomy

SW Right

S I did know, but it hadn't sort of registered straight away. (um) and then I thought cricky this is really going to hurt - now (laughs) despite the fact that I had already been in a lot of pain for hours and hours, I then got sort of a bit scared. I said to my husband, I don't know how much of this is going to hurt. And (um) I asked the stupid question 'is this going to hurt'. 'Well no because I am going to give you a local'. (pause) Which ok, fair enough, that's going to hurt too, but at least I won't feel the majority of it. So she administered the local and within minutes, ent…, ent.., well put the forceps in me…

SW Right

S …and pulled him out, so I wasn't even very numb. Well I don't think I was anyway…

SW Right

S …it was far to quick, and because they told me it was the same stuff they use to take out teeth

SW Mm

S …I thought at least the Dentist gives you the courtesy of prodding you first to see of your numb, and can feel that, but there…

SW Right

S …was none of that. She was quite barbaric (slowly chooses word), I thought in her mannerisms.

SW Ok

S ..so the end result you know, er, well, I have to be honest I am dealing with it now (wiping more tears). But it was quite (pause). The episiotomy I don't think I felt that, I don't think I felt her cu…(stutters over word) cut me. But I did definitely feel her stitch me at the end

SW Right. And you mentioned you wanted to, I mean you laboured in water and reading…

S Yeah

SW …what you had written in your diary, you had done exceptionally well, having laboured all that time

S Yeah, none of this was my fault which was so…

SW No

S …awful.

SW Had you had that thought, that this was your fault, that you had sort of…

S No. No because right from half past three in the afternoon, he was born at

quarter to ten at night, right from half past three, they had told me his head was coming in off set,…

SW Right

S …so it was the side of his head that was coming down first, and that was why it was taking so long to get to fully dilated…

SW Right

S …and that was why I was pushing with all my might he was coming slowly, so I did know right at the end when I agreed to the forceps that, that was happening and it wasn't my fault, 'cause I do sincerely think that he would have been born by tea time (laughs), if he had come through at the proper angle…

SW Right

S …or the angle that made it easier to deliver, so (um)

SW Did that make it any easier for you to cope with. Reading in your diary it has been very traumatic for you, and just seeing you now (telephone rings) – it's alright, I'll let you get that.

(Tape off for a couple of minutes)

I was just saying that does it make it any easier for you to cope with knowing that it wasn't your fault, as you call it? That there was a reason why all of this happened? So you didn't have to blame yourself and you needn't blame yourself.

S I've had that conversation with my husband since, actually. I know a lot of people when they fail to breast feed, fail to deliver naturally and have a C-section, and all the rest of it, you start blaming yourself, but i haven'' actually started to blame myself because the midwives did make it very clear that I was doing a fantastic job and that it wasn't me, it was just the way his head was coming down.

SW Right

S So the fact that I was exhausted and needed a bit of help, no I didn't feel like a failure and I make sure I don't get that in my mind. I mean that's just something else to stress me out (laughs)

SW Yeah

S No, no I haven't ever felt that it was my fault, although I think I could have delivered naturally. They said to me right at the end, if you keep going with this you will get him out, but it will take a while because of the way his head was coming. So I (um) just couldn't have done it any more.

SW Mm

S There was no way I could have spent another hour and a half pushing (laughs), or another 10 minutes even.

SW While you were pregnant had you thought at all the different ways your labour and birth could have ended up? Or had that not really occurred to you

S (um) my biggest fear was being transferred to Poole half way through…

SW Right

S …and I didn't want that, and I had a conversation with one of the midwives when I was in the water pool (pause) and she said to me, at this point Sarah you need to think a bit further down the line and if you are going to want something like an epidural or, or if we are going to need to do a C-section…

SW Mm

S …we need to start sort of thinking now, and I said to her no, no I am not wanting an epidural. No way, it can get as bad as it likes, I don't want that. I was so determined to do it naturally, (um) and the biggest fear I had was being transferred to Poole for anything…

SW Right

S …medically, like a C-section or an epidural because, because I didn't want that. Right from the start I didn't want that, and I knew that I was to go through hellish pain, and I knew I was probably being a bit stupid really. I felt that it was important to me that I tried to do it naturally and if something happened along the way that made it impossible, that I (pause), would just not blame myself

SW Mm, right

S …and deal with it, but to be transferred to (a consultant –led maternity unit) at my request was not ever going to happen.

SW Right

S Just not ever going to happen, so. For that I'm grateful actually…

SW Right

S …despite everything that happened, I am actually quite pleased that that never came about. Yeah, the thought of having to be transferred, well (pause) just awful.

SW So in effect, just listening to what you are saying, even up to the point when it had been explained to you that you needed help out with James with forceps…

S Yeah

SW …do you think you were in control of everything that was happening…

S No…

SW …at all?

S …definitely not, no. I was a complete mess. I had actually been asked to get out of the water pool because I needed to pee, apparently…

SW Right

S …although I couldn't, but they put a catheter in, so from that point I never made it back into the pool. (Um) because the pushing seemed to do more outside the pool. (um) and they made me push while I had the catheter in which was strange but (um). And I did quite a bit of pushing while waiting, waiting for the Registrar to come after they had called her, and because obviously she was coming I didn't get back into the pool. And the pushing I was doing outside of the pool was doing quite e good job, so by the time the Registrar got there I think the midwives who were surrounding me were quite convinced it was actually going to happen, actually, eventually. But, (um pause). What was the question you asked me?

SW I was only just asking if you felt in control of your labour…

S Right, yes

SW …and although you had the forceps for the birth, whether perhaps during the labour you felt in control?

S I felt in control throughout the labour, definitely. (Um) definitely, although I was being instructed as to what positions to get into, I felt I was doing what I wanted to do right the way through, until the Registrar got there.

SW Right

S When I didn't feel in control at all. But until that point I did. Completely

actually. I am not looking back on the whole labour experience as being horrendous as I think it was ok…

SW Good

S …it was painful, but it was ok. But at the point the Registrar got there, I lost it completely.

SW Did you feel out of control, or that that control had been taken away from you and you couldn't get that control back at that point?

S (Pause). I felt out of control once I had made the decision to have forceps because she wasn't explaining what she was doing to me. And I did feel, I did feel like I was just a number and I wasn't a person – do you know what I mean?

SW Mm

S (um), that's the point I felt out of control. Not making the decision, because I think I found it quite easy to make the decision, because I knew I couldn't push any more

SW Mm

S I knew I had reached a point where I was just exhausted. (Um), if she had explained to me throughout the forceps procedure what she was doing, as the midwives had throughout the whole course of my labour – they talk to you at every stage, you know exactly what is happening, what they are going to do and all the rest of it. If the Registrar has been as forth coming with information about what was going to happen, I think perhaps I might not have felt so out of control, and maybe I wouldn't have made such a scene when she did the forceps. Because my husband had to hold me down.

SW You mentioned in your diary, you had to pinned down, as you put it.

S And that wasn't an exaggeration either – he literally had to hold me down.

SW Did you feel at anytime from having given birth to James and any time afterwards that you started to get back in control.

S Er yeah, quite quickly afterwards actually. Although I have had tearful moments when the midwives come, if I'm speaking to my mum about it I do have tearful moments. I think pretty much straight away, despite the fact I was in quite a lot of pain I did get my control back. I able to deal with him, I found it difficult to deal with visitors because of the pain I was in and I had to sit as apposed to lay because if nobody was here I would just lay down. Because of space and people sat on the sofa you can't lay down you've got to sit and I am just constantly shifting position. But no I am quite a strong person mentally normally, so I was able to get myself together and not loose it.

SW And as far as having had the stitches did at any point you were feeling out of control of that, you know sort of going to the toilet…

S Oh gosh, going to the toilet….

SW …and walking around

S …that's awful. The first three or four times I went for a poo were just incredibly awful, because I knew I needed to go so desperately…

SW Mm

S …and I didn't feel like I could but I knew that I needed to, even after the Sennacot actually, which did help me to go, I didn't feeling comfortable going at all (slight laughter), because I was so scared…

SW Right

S …I was sat on the toilet thinking, gosh everything is just going to burst open, I

am going to bleed everywhere and it is gong to be awful.

SW So a lot of it was fear you are saying…

S Fear, definitely fear yeah, because it was a couple of days before I even actually looked down there…

SW Mm

S …to see what the stitches looked like because I couldn't just bear to look. I mean I was washing it and everything and I felt it with my hands, but I didn't really know…

SW That was one of the things I was actually going to ask that (um), was that because you didn't want to know what it looked like…

S No I didn't want to know, I didn't want to look, I didn't feel I could. I mean, because I knew I'd seen diagrams of where they cut you and where they stitch you and I knew. And I could feel the swelling when I washed myself, and I thought it is just going to be too awful to look at, and I know it's there so there is no point…

SW Yeah

S …in looking at it just yet.

SW Were there any particular visions you had in your head about what it was going to look like

S (Um), it actually looked, by the time I managed to look at it it did look a lot better than I thought it was going to. I thought it was going to be a lot more (pause) bloody than it was.

SW Right

S But I had made a real effort to keep it as clean as I physically could and I was bathing two or three times a day. So it didn't look as bad as I thought its going to be actually, not half as bad.

SW With the swelling that sometimes makes you feel a lot bigger than they actually are. With the swelling and that did you think that it was quite…

S (Um) I had a bit of puckered stitching which, if you cut a piece of fabric and stitch it back together again, at the end of the cut…

SW Mm

S …so nearest my bum end there was a bit that had sort of been over lapped and there was more fabric, or more skin one side than there was the other.

SW Right

S So where she stitched me and there was a bit of over lap of skin that bit swelled and because it was rubbing on my other bum cheek, if you like…

SW Yeah

S …it obviously took a long time for the swelling to go down. So that I think was the worst thing. I could have coped with the stitches because my vagina end, although is still gaping and doing all sorts of horrible things, it was the swelling at my bum end that was making me so uncomfortable to sit…

SW Right

S …I think more than the actual stitches themselves. But I did rely quite heavily on the painkillers for that reason, because according to the midwives that have been they did make quite a balls of stitching me (sniggers).

SW Right

S Which only makes me hate that Registrar even more (raising voice)

SW That couldn't have helped you come to terms with anything any quicker…

S No. I don't think she cut me badly I just think she did make a bit of a hash of

stitching me, but that might have been she was trying to rush because I was making such a scene about being able to feel it…

SW Right

S …so I don't know if I was partly to blame for that, but the whole, the whole stitching thing, although it is settling down now but is gaping in places (um) the lump at the end of the stitches was probably the one thing that was the most painful actually.

SW Was there thing you had to try and adapt yourself to do, like with sitting. Did you start to experiment how was the best position…

S Yeah I was actually worried I was going to have to see a chiropractor afterwards because I have really been sitting off set and I don't expect it is doing my back any good at all. But yeah, if I wasn't laying down and would be sat to one side, to one side…

SW Mm

S …certainly on my left bum cheek, I've spent a lot of time sat there, or with my legs up on the sofa like that…

SW Right

S …off to one side. But really laying down was the one thing, although it didn't stop the pain, it did relieve the pressure a bit.

SW Is that how you fed James as well, lying down…

S Feeding was, is incredibly painful, probably the first week I would say because although I can do it lying down, and I was doing it lying down in bed, there are situations where, you know he was getting such bad wind as well and still does that I needed to try and feed him in more of a sitting position, him in a sitting position so (um) realistically I was just sitting here with pain, hoping that he would hurry up (laughs). I think that was all that I was doing. And sitting up in bed, 'cos for the first week as well I was bleeding quite heavily when I was feeding him, which was where my uterus was contracting when he was feeding…

SW Mm

S …but he (pause), I was just hoping he would finish as quickly as possible really. Yes feeding was probably the one thing that was the most painful because you are restricted to how much you can move…

SW Mm

S …(um) my first bath my husband bathed me, when I bathed at home (laughs)

SW Was that you're first bath at home?

S Yeah, my husband, I couldn't, I laid in the bath and couldn't sit up again (laughs) so he did everything, bless him. He was very good. Yes I would say sitting and feeding were definitely the worst things (um, pause) feeding being top of the list I would say

SW Mm. And how about feeding yourself when you came to eat.

S Oh that was difficult too…

SW Yeah

S …I was actually not able to eat at all. (Um) I was eating but I tended to do it knelt at this table, without trying to, I couldn't, I couldn't sit for long enough, because you need to be in an upright position to feed yourself don't you? You can sort of sit back a little bit when you are feeding him, but (um, pause), feeding myself was very difficult, for again a good week, I would say and I was eating and stopping and sitting or laying down in between and coming

back to it.

SW Mm

S I knew I had to eat because I'm breastfeeding, and I was hungry but I tended to eat in front of this table to eat. That's how I did it (pause), it was so awful.

SW Who was the most helpful to try and get you through these past few weeks?

S (Um), my husband and my mum. Equally I would say, both of them. (Um), my husband said to me, and I think I wrote it in there (pointing to the diary), soon after we had him, I think I will cope with you healing better, because he saw what had happened. He said I do think I can empathise with what you are going to go through… (baby crying loudly over tape)

SW He could understand?

S …because he'd seen her cut me, he did watch it, he watched the whole, he watched the forceps delivery and everything, because he was down that end. Which I found a bit (pause), I wasn't bothered with him being down that end, but I found it difficult to suss out why he was down that end.

SW Right.

S (baby crying, all right little man).

SW But consequently he's now appreciated what you have gone through, how it is…

S He's eased off a little bit, 'cause I am able to move around a little bit more, a bit like out of sight out of mind. He didn't look down their until 2 days ago…

SW Right

S …since I've been home he wouldn't. (Um), I wasn't particularly comfortable with him looking down their either. Two days ago he actually looked at it and said, oh it's not that bad…

SW Yeah

S It was sort of, what's that, what's that where it was gaping. (baby crying loudly, patting baby on back saying, OK, OK – just let me get a dummy)…

SW Yeah (taped turned off until Sarah got dummy then turned on again).

S …certainly, I mean my husband and my mum, they were the two, I'm not sure I would have been able to cope without my husband, being as supportive as he has…

SW Right

S …a couple of time I have kind of lost it a little bit. And he would take, he had nearly three weeks off work you see in the end, so when I said to him you., you've got to take him from me (phone rings, taped turned off until call finished).

SW And you mum, was that for things like helping you get things and doing the chores…

S My mum's always been the sort who would never interfere, never turn up unannounced, but I know if ever I said to her can you come over now, she would come over like a shot. And she did back off a little bit because my husband was off, but I knew she was there if I needed her…

SW Yeah

S …she's been a real rock actually, and because my husband works weekends, my mum and dad have come over weekends and taken him for a walk to let me sleep for an hour…

SW Right

S …real helpful stuff. You know things I wouldn't have thought of doing. I

went over to their house on Saturday and they had him for an hour and I went and slept on their bed for an hour. No it's, it's just that I can be myself around my parents, it's easier…

SW Yes

S …and they have certainly helped me catch up on sleep. And my husband, because he can't help me with the feeding…

SW Right

S …because I am breast feeding, (um) when he was off during the day (um) he was brilliant, I mean he did all the house work and everything without me even having to ask him. All the washing and ironing and everything.

SW Did you find that helpful knowing the peripheral things were being done?

S I did really care. I wouldn't have cared if they weren't being done…

SW Right

S …he was certainly keeping on top of that. The washing needed to be done. Each time my mum came over she would ask if there was any washing or ironing to be done, but Paul had done it all. They were almost fighting over who was going to do it (laughs), to begin with, bit the novelty has fallen off now. (baby crying loudly, long pause to settle him)

SW After you had given birth and you had finished being stitched, when you had your first wash, I think you mentioned you had a shower…

S Yeah

SW …how did that make you feel getting up for the first time.

S I was really, really wobbly. Really quite er, really felt quite fragile. Actually one of the, I think she was a Sister or a nurse or something, she showed me where the shower was and where all the bits and pieces were, and I actually thought she was going to help me but she went (laughs).

SW Right

S I mean I'm sure if I said to her, can you help me, can you stay she would have done. And she asked me if wanted my husband to help me, and I thought, probably if I try and do it on my own and I need some help, then come and (um), it seems to take forever just to have that one shower. I didn't wash down there, I just held the shower thing underneath me, and I thought I can't bear to touch it…

SW Mm

S …because I just don't know what is going on down there (um), and I soon as I got out of the shower there was blood coming out of me…

SW Mm

S …so I blood everywhere and all over the towel and I'm thinking, am I actually any cleaner than when I went in. (Um), bit because he pood on the way out I needed to have a shower…

SW Mm

S …it was evident I needed t have a shower, so yes I was quite scared actually, I was quite scared…

SW Mm

S …and I didn't touch down there, I think I just couldn't bear to.

SW Did you find that being able to wash was like the end of the birth bit, it had finished and this is the rest of it now?

S Yes because when I finished the shower and I walked into the room (um), they had moved all my stuff. My husband had moved and the baby was in the room

where I was going to spend the night…

SW Right

S …and I walked into that room and it was just so peaceful, and he was quite chilled, he just lay there, he was awake but was just (pause)…

SW Gazing around

S …gazing around, And my husband was sat in the chair looking like he was going to sleep, quite badly (laughing), and there was quite a different sought of atmosphere, having gone from this room (pause) which quite honestly was just covered in blood and bits and bobs everywhere to this room which had a bed and it looked all comfy and all my stuff had been moved and I was quite clean, and I felt, OK this is OK now...

SW Right

S …especially as he wasn't crying…

SW Yeah

S …but shortly after that, about 10, 15 minutes later my husband left and went home to go to bed and then he started and cried all night (laughs)…

SW Oh no

S …so it wasn't quite as relaxing as I thought it was going to be, but (um, pause), it was quite a different atmosphere in that room because they had moved all my stuff and you know, I had focused all my attention on the shower and when I came out everything had been done for me, that was quite good.

SW You also mention in the diary a couple of times about the amount of bleeding you had and having to cope with that, how did you get on with that?

S During delivery or afterwards?

SW Afterwards.

S Afterwards, (um)…

SW Had you expected to bleed that much?

S Yeah, yeah I think I had (um, pause). Yeah I've had friends who have had babies who say you bleed and need x, y, and z towels and they are about an inch thick, and the rest of it, (um, pause). I actually coped quite well with that I think, because I was actually prepared for that. The bleeding from the stitching I found harder because the other bleeding you expect…

SW Mm

S …and to begin with because I needed to wear such thick towels it did make sitting even more uncomfortable than I think it would have been…

SW Right

S …had I not worn a towel, but no I mean I was changing it every hour at certain times of the day, but (um), having the bleeding was ok, but its getting to me now, I am fed up with it now.

SW Because you did mention once you got into thinner towels and wings that you felt more comfortable you knew things were slowing down a bit and you could sit…

S Especially when people are here. When people are here and you've got big old thick towel and even in tracksuit bottoms people can still see that it's there. And I know that anyone who has had kids knows you've got to wear them, but I was like, I didn't want people to see me wearing them. But certainly now, you can wear ones that are almost paper thin…

SW Yeah

S …can't you, they're brilliant, they're much more comfortable. It's ironic that at the time when you need to be wearing thin ones is the time you have to wearing thick ones. So (um)…

SW You also mentioned it affected the way you walked, having the thicker towels as well. You felt a lot more uncomfortable and ungainly.

S Yeah, just everything was more uncomfortable and I think I would have been in a lot of pain without the towel on, but the towel just seemed to increase the pain more because it was just there…

SW Mm

S …and even at one point I thought to myself, God you've even got to continuously wear knickers. Which actually I could have not done with doing that either. I read somewhere that you could just lay in the bed on a towel, without any knickers or towel on and let the air get to it and that would be a good thing, but I just couldn't bring myself to do that….

SW Right

S …I wish I could have just done that because it would have been more comfortable…

SW Right

S …yeas, having to wear knickers all the time, because I don't generally wear anything in bed. So all of a sudden you go from wearing to nothing to wearing a massive towel with knickers, and because I am leaking I have to wear a bra top with pads as well, so it is er, it is er, different.

SW Some of the other mums I have talked to, talk about getting back to normal. Have you had any thoughts about that over the past couple of weeks, about getting back to normal, whatever normal is?

S I would really like to wear an underwired bra now (laughs). Normality for me is quite a way off actually because my husband has just gone back to work…

SW Right

S …and I am not really in any routine at all and probably wont be for some time. So I think the most prominent thing now is just how long it takes both of us to get up and get ready and get dressed even. (Um), because I had quite a demanding job, I am now having to reverse form being in work and being in control and work…

SW Right

S …to try and be in control here and it is quite a different role and I do think you needn't tie yourself down to times and things like that, but normality (pause), I don't know if I will ever get into any sought of normality actually (laughs).

SW Are there any goals that you would see, yeah that is a bit more like me, that's getting back to me?

S (Um), yeah, what did I do the other day that I thought that's a bit more like I would do? (Um), I think because I am a bit of a planner…

SW Mm

S (Um), I started thinking about booking a holiday for the summer and that was a bit more like me…

SW Mm

S …last Saturday I said to my husband that we would probably need to go somewhere in the UK, and get somewhere booked so we have something to look forward to…

SW Mm

S …and that was more like me. Whereas the two weeks after he was born I was just going with the flow and really even thinking about anything. I didn't use that section of my brain for a couple of weeks (laughs). (Um), yeah, (pause), yeah it's quite a shock actually, quite a shock to the system I think. Especially if things don't quite go as planned. And then dealing with things (um), that you obviously didn't have planned down there, I was wondering god is it ever going to be OK to have sex again…

SW Yeah

S …those sorts of things, normality being obviously that side of things as well and I was just can't ever imagine wanting to be if I'm honest. I know I will but it is hard to imagine (laughs).

SW You have talked, written towards the end of your diary, the thoughts you have had a night and some of the dreams you have had….

S Yeah

SW …and I don't know if they have settled…

S My husband has been having the same dreams, it's weird, he dreamt that I divorced him last night. I think both of us are probably just finding our feet with it because we've got this extra person in the house and we've never had that before and it's er (pause), yeah I haven't had any since actually. It must cross everybody's mind whose had a baby because your figure is not quite what it used to be, and you're a bit emotional, you can't perform down there and it's all (pause), you're tired all the time…

SW Yeah

S …you're probably not yourself, quite yourself (pause, James crying out and Sarah calming him), so.

SW A few times again in the diary you mention and have talked about 'down there' or 'down below' or 'nether regions' is that names you would normally use or…

S No, I'd normally call it that

SW …yeah, yeah, because some mums I have talked to, used words as if they don't want to remember it. They would try and use words to ignore what was actually going on.

S Yeah (pause), actually the main reason that I am calling it 'down below' is that we have an affectionate name we call it. My nieces who are both girls, they call it they're 'ninny', so it is a family thing that we always call it the 'ninny'. Because obviously you don't want to call it vagina in front of little kids…

SW Yeah

S …but obviously if I used that word you wouldn't know what I was talking about (laughs).

SW That's OK.

S If I or my husband talk about it he asks if my ninny is ok (pause), you've got to make light of it, haven't you?

SW Do you find you can make light of it?

S Yeah, I find I can, yeah. If anyone asks me 'how are you' or 'how are you healing up', mostly lots of female friends, I get a bit like this (tearful), so I think if anyone shows me a bit of compassion, I just get a bit emotional…

SW Mm

S …but if we are not talking about it I can just put it to the back of my mind, and forget about it…

SW Mm

S …it's only if my mum says 'are you alright down there', 'how's it going' or if the midwife comes in and looks at it and shows me a bit of attention (laughing, pause), I'm an attention seeker

SW Did you find that the heat treatment you were having at the hospital helped?

S I couldn't tell you actually, I couldn't tell you if it did or not…

SW Right

S …because I never felt it, I never (pause), I was always a bit sceptical as to whether or not it would work because it didn't seem to do anything…

SW Right

S …I just laid there for 10 minutes and I couldn't feel it…

SW Right

S …but the midwives who have come have all said it is wonderful and that you should do it if you get offered it…

SW Mm

S …and I had four or five treatments in the end, and I did think it reached a point where I was getting better anyway, and perhaps I was saying that it worked, but it don't know if I would have healed the same without it, I don't really know. I stuck at it and I went to each one.

SW How did you manage, because you had to go up to the hospital to have it done, and you are quite a distance from the hospital?

S It was quite hard actually, but I made sure in my mind that I knew I needed to make the effort to do that…

SW Mm

S …but my only worry at one point and even still now, he goes for five hours without feeding, or he goes for an hour and a half and if he went an hour and a half and I wasn't back, Paul would have him screaming, so what we did was that each time I went to the hospital Paul drove me there with him in the car and then sat in the car and waited for me. (Um) which again was really sweet, because again my husband is not the most patient of people. But he did it because he knew he had to because if he stayed here with him screaming there wouldn't be a thing he could do about it so…

SW Mm

S …yeah I did make sure that I went to every one, but I was always very sceptical as to whether or not it worked…

SW Right

S …but I am sure it did, but.

SW Sometimes it is, talking to other people, it's knowing you are trying everything you can…

S Exactly

SW …I mean you've talked about go out to buy some lavender oil to help the healing. Did you manage to do that?

S Yeah, yeah I did that, the day the midwife said to me that yu need to get some, so you know, it was the day she came in the gaping section, she said it was leaking fluid of some description…

SW Right

S …and I hadn't noticed that. Then she said because lavender oil is antibacterial as well as the healing, I thought cricky if it is beginning to leak stuff it could be getting infected or something so I sent my husband down to get the

lavender oil. And from that point on I really was having baths about three times a day. I was having them twice a day any way, but the lavender oil seemed to help quite a lot…

SW Mm

S …and the healing process seemed to accelerate once I'd got that lavender oil actually…

SW Interesting

S …whether or not again it had turned a corner without it I don't know.

SW Did you find that quite positive, again it was something that you were doing and be in control of?

S Yeah, I have done everything anybody tells me. Like the heat treatment she did, and I did as many as she told me to have and the lavender oil I did, and I even had a pack of frozen peas between my legs, because the midwife said that that sometimes helps. So I have done everything I could physically do because I would be silly not to I think….

SW Right

S …when you are in that much pain I think you would do anything, wouldn't you. I think I'm going to try it and if it doesn't work there is nothing lost, yeah. (Long pause), I think sleepless nights would have been easier to deal with if I wasn't in so much pain. It's the one thing I said to my husband it a shame that I have to got to be in the pain and I have to get up and feed him, that doesn't seem quite evenly balanced to me (laughs). You know, can't I just be in the pain and you feed him – he said I can't do the Sarah

SW So tiredness was quite a difficult thing to come to terms with…

S Tiredness was making the pain worst I think…

SW Mm

S …because each time I heard him crying in the night, I thought, because it meant I had to get up and get into a semi-sitting position which meant more pain and although I have never struggled to get back to sleep, which I am sure I never will…

SW Mm

S …they're will always be the time, but (um) I think anybody who is getting enough rest and sleep can deal with a certain amount of pain, but when it is ongoing like that…

SW Mm

S …and you are having night after night of broken sleep I think the pain just gets to you more, I think. It certainly did me. Not so much now though, because it is not hurting now…

SW Right

S …not really

SW So you feel it has turned a corner as far as the swelling and the pain you have had there.

S The last week, yeah the last week it will be a week tomorrow since I have taken any voltarol (um), but I was, although they gave me a week's worth of voltarol when I left hospital I ran out and said t the midwife I'm not sure I am going to be able to cope without them. She said well see how you get on today and if you can't get on without them, get yourself down to the doctors. And by 3 o'clock that afternoon I was down there saying can I have some more please…

SW Mm

S …so (um) yeah, I haven't used all that I have been given and I've stopped taking paracetamol now. So yeah I think (um) certainly pain killer wise, what I had certainly seemed to help. But I had dips and lulls during the day. Between three and four in the afternoon seemed to be a real time of day when I was in a lot of pain, so I made a point of at 2 o'clock to take some tablets to try and get them to kick in before three…

SW Right, you said you were going to try that in your diary to see if that worked

S …and I did, then some of the bad time was in the evening when they wore off.

SW You also mention in your diary it helped to write things down…

S Mm

SW …how did that help you, can you explain how that helped?

S (Um), I think because each day knew I needed to write something, I would make sure I did that, and er, while it was fresh in my mind as well, but to write about the birth, it helped to get it off my chest I suppose. It's like telling somebody about it, it felt same thing, felt the same way…

SW Mm

S …and also I think because my husband read it before I gave it to you…

SW Right

S …I liked the fact that we wanted to read it and I thought that's a good thing because have written it down and it has given him the opportunity to read my thoughts. I thought that was quite helpful too, quite a helpful thing, 'cos he could have let me give it back to you and not looked at it…

SW Mm

S …but he asked if I would mind if he could read it and I thought crickey that's not like him either. He's been quite sensitive, he has (laughing). So yeah, no I think it's like anything else if you have been through an experience, whether it's bad or good talking about it's got to be a good thing, 'cos you are letting it all out aren't you?

SW Mm. You talk about this being an experience, can you compare that to anything else that has happened to you or…

S This is way up there (um), I don't know really. I have had laser treatment on my cervix when I was about 20…

SW Mm

S (um, pause), I didn't have cervical cancer…

SW Mm

S …but I was probably on the way to getting it, but I had that under general anaesthetic, and although I was in pain and bled afterwards it wasn't anything like this. I think this, this affects (pause) your emotional state as well, because they say you can be in tears after a normal birth and you not in pain afterwards. So to be in pain and to have had a bit of a bad experience and bad memories plus to be a bit emotional anyway, I certainly couldn't compare it with anything I have ever been through. I've never really had (pause), anything, I mean I am not saying that this is definitely not a bad experience for me, definitely not a bad experience, but when I talk about the birth probably that was a bad experience for me. But because through life I have been lucky and not really had any bad experiences. My life has been quite rosey, so for me to be hit with an experience like that…

SW Mm

S …was quite hard, quite hard

SW So you talk about this not being a bad experience, which is helpful to hear, so the experience of your stitches, and the swelling and the pain, that is something that just fits into the whole birth story…

S Yeah

SW … in effect that is just something that happened in a story of giving birth

S Yeah. I haven't separated it from the giving birth experience. That's just been part and parcel of it

SW And other more positive things have helped you manage to cope with that?

S He far outweighs anything I have been through because (pause), I mean he's, he's is absolutely gorgeous (laughing). I would never look back contemplating I wish I had never given birth, never been pregnant. There is just no way I ever would look back on this and think (telephone rings, taped turned off). There is no guarantee I suppose that if I had had a birth without forceps that I still wouldn't have had an episiotomy. So I am linking the two together…

SW Yeah

S …the forceps and the episiotomy, I mean they may have still have had to cut me or I may have torn…

SW Yeah

S …so I still might have had the pain and the stitches and everything else that goes with that…

SW Yeah, yeah

S …anyway, so er, (pause), it is definitely fading. I mean I came out of hospital saying there was no way I was going to have any more children…

SW Yeah, you said that in your diary…

S …how could I ever put myself through that again, and here I am three weeks down the road thinking, well I probably do this once more. Just for him…

SW Yeah

S …so that he has a brother or a sister. They say you forget, I don't think I would ever forget but I think I will just shut it out into a part of my mind

SW They say some things fade, or they can manage to put things into perspective and then other tings come along that change your mind…

S Yeah. It's much easier to say that when you are not in excruciating pain, which I am glad to say I am not.

SW Yeah. Just to finish up then, could you express perhaps what was the most difficult thing, from the birth onwards?

S From the birth onwards the most difficult thing (pause), sitting, eating and feeding and the pain combined with the tiredness I would say…

SW Yeah

S …because the bleeding I could cope with. (Um) I think the majority of it I could cope with, it was just, I wasn't expecting to be in so much pain as that afterwards…

SW Right

S …you don't think about, in the lead up to the labour you don't think about what's going to happen to you afterwards, you just think about gosh you are going to have this wonderful baby and because everybody tells you that as soon as you have given birth the pain goes. Well yes it would do if you had given birth naturally and nothing, well I did give birth naturally but…

SW I suppose the contraction pain goes

S Yeah, yeah you don't think about how much pain you are going to be in afterwards, plus with having to cope with a baby, so that I think was the most difficult thing that I wasn't expecting any of that…

SW Yeah, yeah

S Yeah that's probably it. If someone had said to me you are going to cut, and you are going to bleed quite heavily and you're going to need really strong pain killers and find it difficult to feed because sitting is going to be a problem, then I could have coped with it more. But I was like cricky this is really bad…

SW Had there been any pint during your pregnancy that someone had tried to explain that it doesn't always go right…

S Yeah, but I think you just ignore…

SW …you ignore that yeah, yeah. I've heard mothers say that as well

S …that wont be me, I'm going to have a water birth it wont be me. I didn't even listen properly when they talked about caesareans. We went to every antenatal class…

SW Yeah

S …and they went through all the different pain killers and that…

SW Yeah

S …because I was going to labour and deliver at the maternity unit I was (um), they were talking about epidurals and that didn't apply to me. And then started talking about C-sections which I knew pretty much, quite a bit about them any way…

SW Yeah

S …and I've watched the programmes and you know, I've read about C-sections. But I switched off, I completely switched off because I knew I couldn't have an epidural at the maternity unit and I knew that I wouldn't have a C-section unless it was a dire emergency…

SW Yeah

S …and even hen they talked about Pethidine because I didn't want that either, I thought yeah, yeah, yeah, yeah. I was only ever paying any attention when they were actually taking about labour and the water birth, and gas and air and (um), and I really wasn't interested in bits that probably…

SW Yeah

S …I did listen about the forceps, I did because they showed you the tool they used to break your waters…

SW Yeah

S …if it was necessary, and the thing they put in the head for monitoring and (um, pause), I'm not saying I didn't listen 'cause I did listen, bit I sat there the whole time thinking I won't need that, that won't be me (laughs).

SW Is there anything you felt you could have done with after the birth with the experience you have now?

S They need to design something for you to sit on…

SW Right

S …I know my mum said when she had forceps and episiotomy with my sister, that she had a rubber ring. And I said to the midwife, you know, where can I get one from because I need to be able to sit. And she said I wouldn't use one because they are not good for circulation and blood supply…

SW Mm

S …so I did what she said and didn't use one, but I thought god there must be something someone can design so you can sit comfortably, well not comfortably, more comfortably…

SW Yeah

S …to allow for the space the pad is taking up and all the rest of it. Because it's ridiculous, you look like you've got ants in your pants trying to get comfortable. And I think if I had something to sit on while I was feeding him…

SW Right

S …that would have certainly made a lot of difference to me, massive difference. I'm sure somebody must be able to design something to allow the blood supply and air supply to get there…

SW Yeah

S …that would have made a difference. I was half tempted to get a rubber ring anyway and not listen to what the midwife said, but I thought I mustn't because if it is going to make the healing process longer, then I am not gaining anything. Yeah that's the one thing I would say.

SW Is there anything you want to ask me, or anything you think I have missed out on that you felt you wanted to talk about?

S No I don't think so, don't think so.

Instructions for completing your diary

Thank you for your help in taking part in this study. What follows are the instructions for completing your diary.

When you gave birth to your baby, your birth canal and surrounding area would have been stretched. It may also have torn or had to be cut.

Everyday, for 10 days from the birth of your baby, please describe in your diary how this makes you feel. Please also describe if this is affecting your daily activities in anyway. Daily activities include tasks like walking, sitting, eating, sleeping as well as caring for your newborn baby.

Write as little or as much as you wish. Do not worry about your spelling, grammar or handwriting, it really does not matter.

Before writing in your diary please record the date of your entry.

Many Thanks

APPENDIX 5

EXAMPLE OF CATEGORIES, SUB-CATEGORIES AND SUBSTANTIVE CODES LEADING TO 'RECOVERY OF SELF'

CATEGORY	SUB-CATEGORY	SUBSTANTIVE CODES
		Not want to know
		Think the worst
	Imagining the worst	Absolutely horrified
		Does not feel small
		Ignorance is bliss
		Not so bad
		Thought it would be a lot worse
		Relief
		Still looked normal
	Not as bad as I thought	A lot better than I thought
		Not half as bad
		You look normal
		Not that bad
		Walking like John Wayne
		Felt like a duck
Recovery of self	Feeling different	Feels large
		Like an old women
		No longer wearing a nappy
		Be clean and back to me
	Wanting to be myself again	Wanted a shower
		Getting better
		Familiar surroundings
		Wearing own clothes
	Own clothes and possessions	Belongings around me
		Having to wear clothes in bed
		Joking about sex
		Reflecting on progress
	Recognising the recovery so far	More philosophical about the tear
		Starting to feel normal again
		Quicker than I thought

Instructions for completing your diary

Thank you for your help in taking part in this study. What follows are the instructions for completing your diary.

When you gave birth to your baby, your birth canal and surrounding area would have been stretched. This area may also have torn or perhaps been cut, resulting in you needing stitches.

I would like you to write in your diary every day, for 10 days following the birth of your baby. Before writing in your diary please record the date of your entry.

I would like you to describe how your birth canal and surrounding area feels while caring for yourself and your baby. Please describe if this has affected you in any way and if you have had to make any adjustments to the way you care for yourself and your baby. Finally, I would like you to describe if any of this was expected.

Write as little or as much as you wish. Do not worry about your spelling, grammar or handwriting, it really does not matter.

APPENDIX 7

AN EXAMPLE OF PROPERTIES AND DIMENSIONS RELATED TO AXIAL CODING - BATH / SHOWER

code – the experience of having a bath or shower
property in **bold**
dimension in ……

Amanda Day 2	Had a shower this morning and was very nervous **(emotion)** but I feel better for it **(relief)**
Amanda Day 4	I am getting braver(**emotion)** with showering/bathing and the loss is slowing
Amanda Day 7	…glad **(relief)** to get home and shower
Brenda Day 4	I still feel as though I am dirty down below – even though blood loss has slowed down, I bath and shower daily – but still feel dirty **(purpose)**
Clare Day 0	Being able to have a shower after the birth was nice **(emotion)** I felt clean and fresh **(sensation)**, with Zack I had an epidural so I could only have a wash. Having a shower made a difference**(comparing)**
Clare Day 1	I left it (going to the toilet)**(purpose)** till I had a bath but it still stung. Doing it in the bath doesn't hurt as much as doing it on the toilet
Clare Day 1	I have had a bath and washed Laura and feel so much better **(relief)**
Clare Day 3	I had a wash instead of **(comparing)** a bath as it stings with the heat of the water and putting with luke warm water and a flannel is better as it does not sting as much as the water is cool and soothes it
Debbie Day 2	Bruising is not quite so tender although sitting in the bath reminded me I was quite bruised.**(relief)**
Fran Interview	Well for instance, when I was actually stepping into the bath in the first place, I felt like you know, it was all, I could just feel the hairs pulling when I stepped out of the bath I couldn't feel that any more**(purpose)**…
Fran Interview	Really, just bathing it in warm water really. And I found just soothed it. That was the only thing I really did. Not a shower. I didn't have a shower for the first week because I didn't want the force of the water to knock any scabs off **(expectation)** or anything and then an infection getting in
Fran Day 1	The bath felt nice**(emotion)** to be clean
Fran Day 2	Had a bath which was very soothing **(relief)**. Moving around very easily now **(purpose)**
Fran Day 3	Had a bath, I find them very soothing and feel a bit better after each one

Georgina Interview	It didn't hurt as much as before **(comparing)** when I had the stitches of course, and but really I wanted to get into the shower to be honest. I didn't want to sit there and feel mucky (laughs), I wanted to get into the shower
Georgina Interview	Like you say, it was the end of the birth process really. It's being clean and back to me **(purpose)** (having a shower)
Georgina Day 2	The whole area felt much relieved **(relief)** by using the bidet or shower
Georgina Day 4	It helps a lot to put the shower on the area and pat dry

Questions to ask:
What is going on here?
What are the similarities / differences?
What do they have in common?
Can it explain predict?

<u>31 October 2003 Code note</u>
Properties and dimensions of the experience of having a bath or shower

experience of having a bath or shower = category

Property (characteristic)	Dimensions (along the continuum)
PURPOSE	feeling dirty, to help pass urine, to be clean, returning to me
COMPARING	Wash in bed, didn't hurt as much as before
FEELING (sensation) (emotion)	clean and fresh nervous, glad, nice, braver
RELIEF	felt much better, glad to get home and shower, reminded me I was bruised (so no relief)

Taking off from this code note I can hypothesise that having a bath or shower is an important part of a daily routine. This may not seem as unusual as perhaps most people wash every day. However it is more than getting clean, washing seems to help with relief of discomfort and helps getting around as well as Georgina also refers to the first wash after having her baby as a sense of getting back to herself. Having a bath/shower has been compared to previous experiences of only having a wash in bed, which didn't seem to be as good as getting in the shower.

<u>Theoretical note written from code note – properties and dimensions of the experience of having a bath or shower - dated 31 October 2003.</u>
This does not seem to be a vital activity. But one that brings pleasure and relief. This activity tends to be referred to early on in the diary. Where as other activities such as going out are referred later in the diaries. These are also things that cannot be undertaken by anybody else. Although walking cannot be undertaken by anyone else,

the purpose for the walking may be able to be done by others, such as collecting a dinner tray in hospital. However someone else can prepare the bath.

Daily living activities can be subdivided into survival; bowels and passing urine and are dependent on the individual doing it. Others are a necessity but can be helped to be made easier by others such as doing the cooking, looking after the baby while eating. Others can be entirely dependent on others such as household chores. However even those things that others can do, women seem reluctant to let them do it and want to achieve it themselves. Is this so as not be seen to be dependent on others, not a very 'cultural thing?'.

PROFILE OF WOMEN PARTICIPATING IN THE STUDY

Name of women and their baby	Number of babies	Age of women	Type of vaginal birth	Category of perineal trauma
Anne and baby Charlotte	2	37 years	Spontaneous	1^0 tear
Brenda and baby Alice	1	27 years	Spontaneous	Labial grazes and intact perineum
Clare and baby Laura	2	20 years	Spontaneous	Intact perineum
Debbie and baby Samuel	2	32 years	Spontaneous	Intact perineum
Amanda and baby Rhys	1	31 years	Spontaneous	2^0 tear and labial grazes
Fran and baby Abby	3	29 years	Spontaneous	2^0 tear
Georgina and baby Charlotte	4	42 years	Spontaneous	Intact perineum
Janet and baby Thomas	1	25 years	Ventouse	Episiotomy
Hannah and baby David	1	26 years	Forceps	Episiotomy
Sarah and baby James	1	30 years	Forceps	Episiotomy
Ruth and baby Ryan	1	27 years	Spontaneous	1^0 tear

APPENDIX 9

Name
Address

Name
Consultant Obstetrician
Hospital
Hospital Address

Date

Dear ****

I am writing to inform you about a study I am undertaking for my PhD studies. The focus of the study is "Women's experience, perception and understanding of their perineum following a vaginal birth". The ways in which I propose to collect the information is for the participant to keep a diary about her recovery from her birth experience over the first 10 days from birth. A daily entry would be sufficient unless there is anything specific the woman wishes to record at the time it is happening. Clear instructions about how to record the information will be given in the diary.

The participants know they can withdraw from the study at any time. If you have any queries or concerns please do not hesitate to contact me.

Yours sincerely

Name

APPENDIX 10

Susan Way
Address
Telephone
e-mail

I am a midwife and research student studying for a PhD at Bournemouth University.

Although most women are fit and well following the birth, physically they may feel sore around the birth canal, especially if they have had stitches. The purpose of my study is to gain an insight into the thoughts and feelings women have of their birth canal and surrounding area following the birth.

The way in which I would like to collect this information is for you to keep a diary about your thoughts and feelings of your birth canal and surrounding area over the first 10 days from birth. A daily entry would be sufficient unless there is anything specific you wish to record at the time it is happening. Clear instructions about how to record the information will be given in the diary. Following completion of the diary I would like to interview you on one occasion, 2-4 weeks later, to talk to you about what you have written. The interview will last no longer than an hour. All information collected will be confidential and you may withdraw from the study at any time

Upon completion of the study, the diary and tape recording will be returned to you, or destroyed if you wish. I will be happy to discuss any of the results of the study with you.

There may be no direct benefits to you from this study, but it is hoped the final research report will provide midwives and doctors with valuable consultation material when planning and implementing postnatal care.

If you would like more information about the study, and would be interested in taking part, I would be happy to talk to you on the telephone. If you would kindly give a contact telephone number to your midwife, she will inform me of your interest. This does not mean that you have to take part in the study, you can make that decision after I have spoken with you.

I would like to thank you for reading this information and I hope I will be speaking to you in the near future.

Yours sincerely

APPENDIX 11

CONSENT BY THE PARTICIPANT

An investigation into the perception's women may have of their perineum following childbirth

I ..... (full name)
of
..... (address)
.....

hereby fully and freely consent to participate in the proposed study named above.

I agree that my General Practitioner can be notified of my participation in the study and that she/he may release information on my past medical and obstetric history.

..... (Name of GP)
..... (Surgery)
.....

I understand that I may withdraw my consent at any stage of the study and there will be no health risk to me resulting from my participation. The purpose and nature of the study has been detailed to me in an information sheet and has been explained to me by:

..... (Researcher)

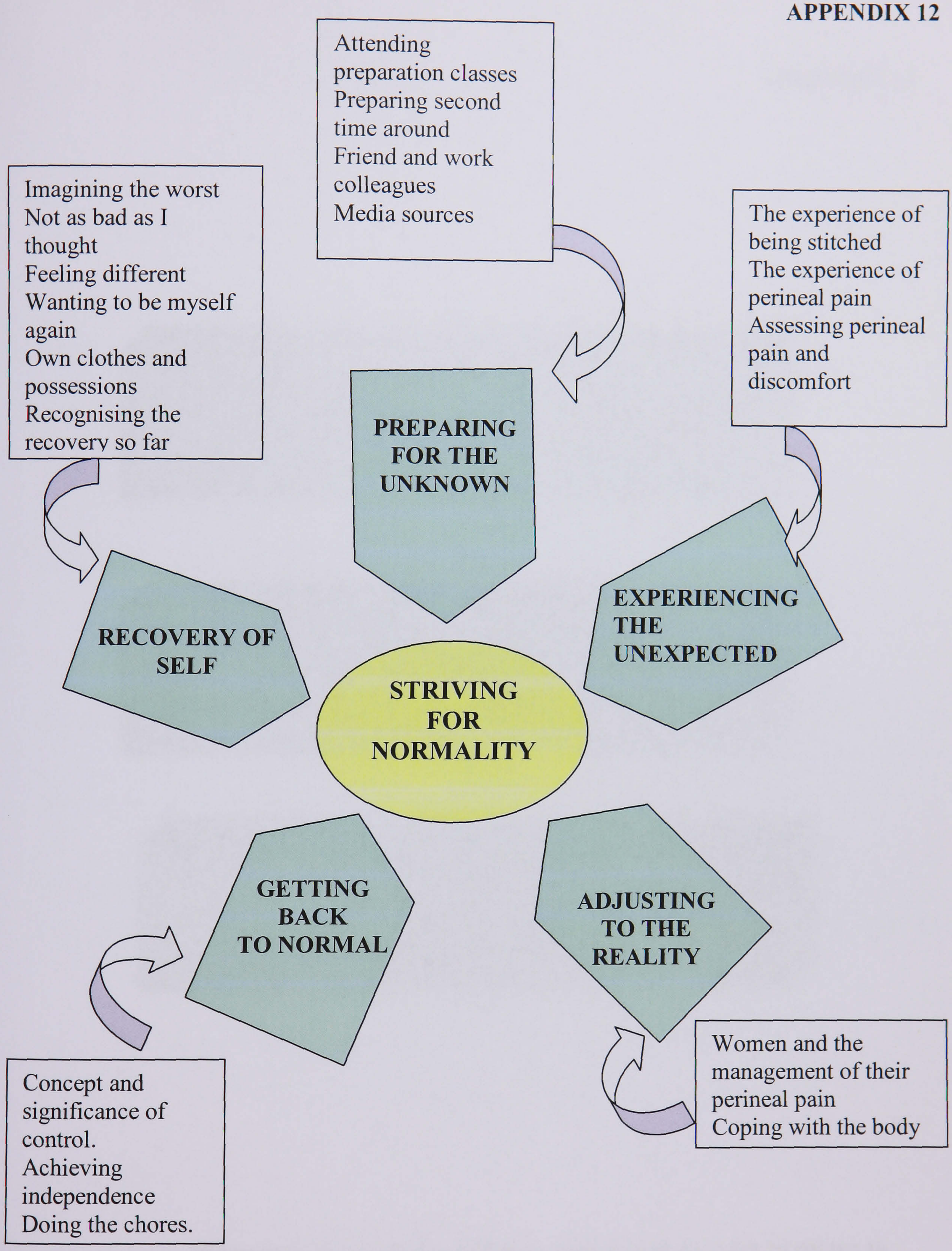
and I have had opportunity to discuss these matters with her.

Signed: ..... (Participant)
Date: .....

DECLARATION BY THE RESEARCHER

I confirm that I have provided an information sheet and explained the nature of the study to the participant and that her consent has been given freely and voluntarily.

Signed: ..... (Researcher)
Date: .....



Derivation of codes and categories

APPENDIX 13

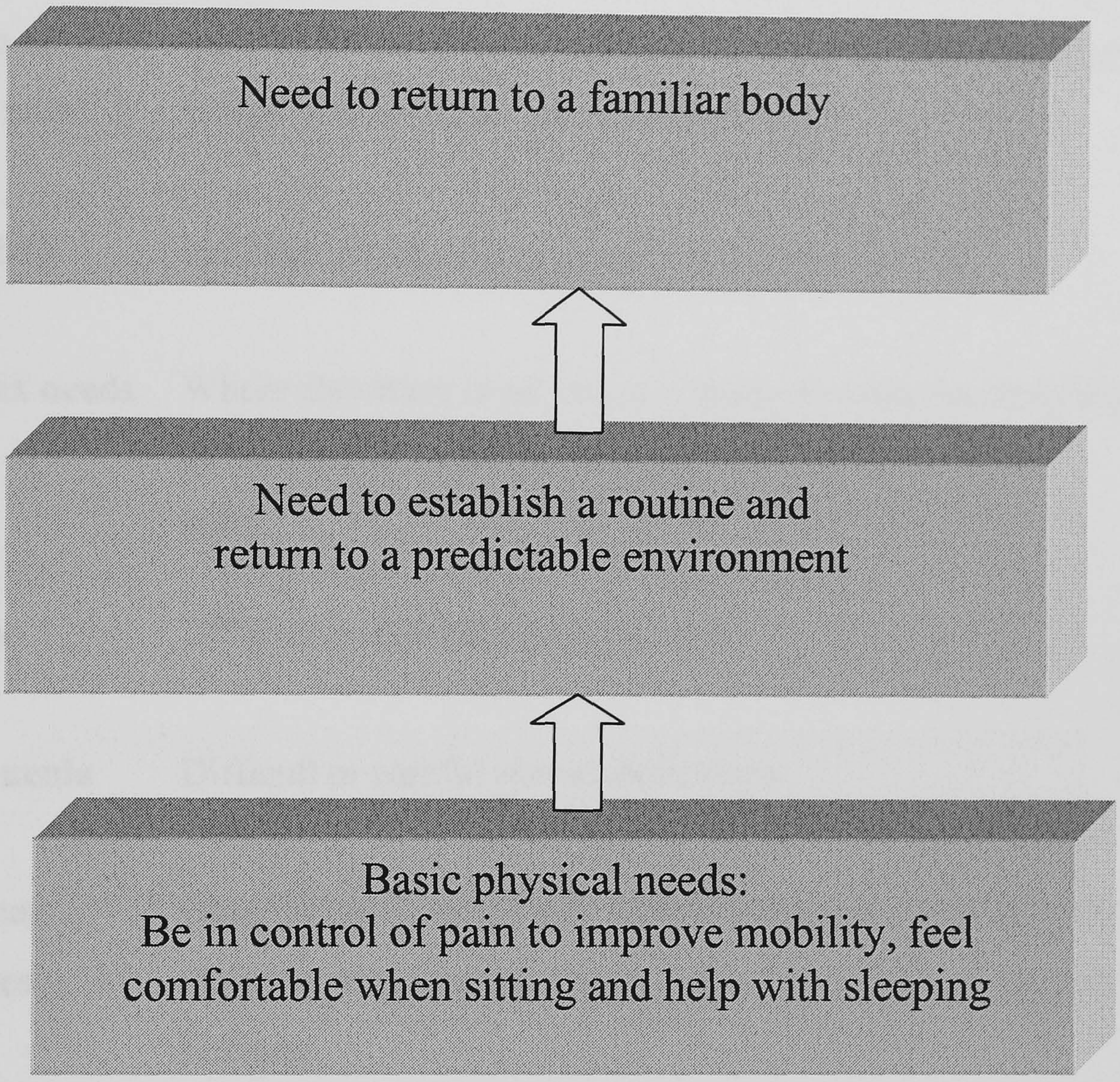


Diagram to illustrate the pathway women took in order to return to normality, based on Maslow's 'hierarchy of needs' (Esenyck 1994)

GLOSSARY OF SELECTED TERMS

Analgesic	A pain relieving drug
Apgar score	A scoring system to assess the wellbeing of the baby within the first 10 minutes of birth
Artificial rupture of membranes	A procedure carried out by the midwife or obstetrician to break the sac of fluid surrounding the baby in order to start or accelerate labour or to view the colour of the fluid
Childbirth	Includes pregnancy, birth and the postnatal period
Complex needs	Where childbirth is no longer straight forward but complication by adverse social or medical needs of the woman or her baby
Dysuria	Difficult or painful passing of urine
Dysparuenia	Difficult or painful sexual intercourse
Electrical therapies	High intensity energy waves are locally applied to the perineum via a machine in order to help relieve pain and reduce swelling and bruising
Electronic fetal monitoring	A procedure where by the fetal heart rate is monitored continuously via a specially designed machine
Epidural	The introduction of a local anaesthetic into the epidural space surrounding the spinal cord
Episiotomy	A surgical incision into the perineum to enlarge the vaginal opening

Gas and air	A mixture of nitrous oxide and oxygen, that is inhaled by the woman as a form of pain relief in labour. Also known as Entonox
Involution	The uterus returning to normal size after the birth
Lithotomy	A position where the women lies on her back with her legs flexed and abducted and supported in lithotomy poles
Maternity Services Liaison Committee	a forum for women, midwives, doctors and others involved in maternity services to meet together, several times a year, to discuss local maternity services and influence local policies
Maternity Support Worker	A non registered health worker trained to support the midwife in her work.
Midwife	A midwife registered with the NMC who notifies her intention to practice to a Local Supervising Authority and who has updated her practice in accordance with the standards published by the Council, and who (a) is in attendance upon a woman and baby during the antenatal, intranatal or postnatal period; or (b) holds a post for which a midwifery qualification is required
Morbidity	Health problems experienced as a consequence of pregnancy and / or birth
Parity	Pregnancies that have resulted in a live birth(s)
Postnatal period	The period after the end of labour during which the attendance of a midwife upon a woman and baby is required, being not less than ten days and for such longer period as the midwife considers necessary

Pudendal block	Local anaesthetic is injected via a transvaginal route into an area around the pudendal nerve
Puerperium	A period following the birth where the uterus and othr organs ar returning to their pre-pregnant state. A period of 6-8 weeks.
Randomised controlled trial	A study to test a specific treatment in which people are randomly assigned to two (or more) groups: one (the experimental group) receiving the treatment that is being tested, and the other (the comparison or control group) receiving an alternative treatment, a placebo (dummy treatment) or no treatment. The two groups are followed up to compare differences in outcomes to see how effective the experimental treatment was.
Second stage of labour	The period lasting from full dilatation of the cervix to the birth of the baby. The delivery of the placenta and membranes is known as the third stage of labour
Spinal	Local anaesthetic is injected directly into the subarachnoid space directly into the cerebrospinal fluid
TENS	Transcutaneous electrical nerve stimulation - when used it stimulates the production of natural endorphins and has the ability to impede incoming pain

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