

## PSYCHOLOGICAL CONSEQUENCES OF TRAUMATIC VAGINAL BIRTH

### Hypothesis / aims of study

Somatic trauma to the levator ani and external anal sphincter muscles are major etiological factors for fecal incontinence and pelvic organ prolapse, affecting 20-30% of primiparae after vaginal delivery. Such injuries are likely to be associated with psychological trauma, partly because of overlapping risk factors, and partly due to resulting pain, sexual dysfunction, changes in body image and symptoms of pelvic floor dysfunction (1). The association between somatic and psychological trauma is poorly understood. The aim of this qualitative study was to examine associations between somatic and psychological trauma after low-risk first vaginal birth at term.

### Study design, materials and methods

Primiparous women with major pelvic floor trauma were identified from a population of 850 women examined in 2 perinatal imaging studies. Levator ani avulsion and major obstetric anal sphincter injuries (OASI) were diagnosed by 3D/ 4D translabial ultrasound (2) 3-6 months after the birth of a first child at term, following an uncomplicated singleton pregnancy. Avulsion and OASI were diagnosed on multislice imaging according to previously published methodologies (2,3). Seventy mothers with documented full uni- or bilateral levator ani avulsion were approached 1-4 years postpartum, and 40 responded and agreed to an interview. Telephone and/ or face-to-face interviews of 35-40 minutes duration were undertaken with a focus on individual experiences. The template comprised open-ended questions on antenatal, intrapartum and postpartum care. The interviewer was a midwife with extensive professional experience. Thematic, purposeful analysis was undertaken. Consistent coding matched identified themes in the template. Saturation of answers was noted at 40 when no new themes were introduced. Approval had been obtained from the local Human Research Ethics Committee.

### Results

Forty women were interviewed 1-4 (mean 2.5) years after their first birth. Mean age was 32.9 (21-40.5) years. Mothers had given birth at term (38-42 weeks) by normal vaginal delivery (n=14), vacuum (n=8) or forceps (n=18). Median length of first and second stage was 620 (range, 90-1440) and 60 (22-317) minutes. Mean birth weight was 3600 (2400-4680)g. Levator avulsions were never identified, and OASI was identified in only 5/40 women at birth. On postnatal translabial US imaging at a mean of 114 days after their birth, 40 (100%) were diagnosed with a complete levator avulsion, and 22 (55%) with major obstetric anal sphincter tears. During interviews the following themes were identified:

- Subjectively inadequate antenatal education resulting in poor preparedness for birth (29/40; 72.5%); "Classes were not satisfactory - I thought that we were not given accurate information."
- No information provided by clinicians on potential postnatal pelvic floor morbidities (36/40; 90%); "We were not prepared for what actually happened."
- Conflicting advice from clinicians before, during and after birth (35/40; 87.5%); "Conflicting opinions from clinicians (were) fairly disconcerting to both my partner and myself."
- Partners traumatized by unexpected events (21/40; 52.5%); "My partner was of no help - he was in shock I think!"
- Long term sexual dysfunction /relationship issues (27/40; 67.5%); "I feel terrible about sex- my relationship has broken up for good and he is in another relationship."
- Nil postnatal assessment of injuries (36/40; 90%); "Health professionals were not attentive to any of this - I felt alone, I still do."
- Multiple symptoms of pelvic floor dysfunction (urinary and/ or fecal incontinence, prolapse, chronic pain, dyspareunia) causing lifestyle alteration (35/40; 87.5%); "I felt like my guts were falling out."
- Resignation: 'putting up' with injuries (36/40; 90%); "This is a hidden injury and I can not share this with anyone."
- Symptoms of post partum post-traumatic stress disorder (PTSD) e.g. poor baby bonding, flashbacks during sex, dissociation, avoidance, anxiety (27/40; 67.5%); "I never doubted that I had PTSD after this. I could not attach to my baby for 6 months. I have to bite my hand to stop myself from telling (other women) how bad your birth and delivery will be."
- Dismissive reactions from poorly informed clinicians to maternal injuries/ symptoms (26/40; 65%). "The midwife said that this was OK... but I knew that it was not normal... The doctors really did not understand the situation... I was in shock - devastated and unable to get any health professional to understand."

### Interpretation of results

Major somatic maternal trauma after vaginal birth is one of the main causes of pelvic floor dysfunction, and it also seems to be associated with significant psychological morbidity up to and including postpartum Post- traumatic stress disorder. Compromised psychological health seems common in this group of women and deserves further study. An increase in partner psychological trauma was also observed due to their presence at unexpectedly traumatic vaginal deliveries. Women complained that healthcare practitioners had not prepared them antenatally for the possibility of a traumatic delivery or informed them of potential subsequent morbidities, that they often gave conflicting advice throughout all stages of pregnancy and birth, and that they did not assess postnatal injuries and/or were dismissive of symptoms of somatic pelvic floor dysfunction with substantial lifestyle impact. Post-natal sexual health problems in this group of women were very common, often long term and in some cases caused relationship breakdown. Most of these women just 'put up' with their symptoms and had not sought help from health professionals by the time of their interview.

### Concluding message

Major somatic pelvic floor trauma suffered during vaginal childbirth seems to be a marker for psychological trauma, and both forms of trauma provide major opportunities for practice improvement in maternity services worldwide. Mothers after traumatic birth are likely to have a reduced quality of life due to both psychological and somatic morbidity. While somatic trauma may take decades to clinically manifest as fecal incontinence or female pelvic organ prolapse, psychological impacts are much more likely to be immediate. Qualitative research to date reveals a very limited understanding of women's post-natal somatic and psychological experiences and subsequent morbidities.

There is a great need to learn how to better help women who have sustained these injuries by acknowledging their concerns and providing diagnostic and therapeutic services. This is unlikely to occur unless health practitioners learn how to diagnose maternal birth trauma properly and account for women's perceptions and needs following traumatic vaginal childbirth.

### References

1. Aust N Z J Obstet Gynaecol 2015; doi: 10.1111/ajo.12286.
2. Aust N Z J Obstet Gynaecol 2013; 53: 220–230.
3. Ultrasound Obstet Gynecol 2013; 42: 461–466

### Disclosures

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