Women's Experiences After a Third-Degree Obstetric Anal Sphincter Tear: A Qualitative Study

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ABSTRACT: Background: *Little qualitative data are available that address the experiences of women who sustain a third-degree obstetric anal sphincter tear during childbirth. The objective of this study was to explore the views and experiences of women in the postpartum period after sustaining a third-degree obstetric anal sphincter tear.* **Methods:** *A qualitative study was conducted using focus groups in a large maternity hospital in the United Kingdom. Two focus groups used a purposive sample of women who had suffered a third-degree tear. One group (*n = *6) had a tear in the index pregnancy and the second group (*n = *4) had a subsequent pregnancy after the tear.* **Results:** *The main themes identified included apprehension about consequences of the injury in terms of continence; body image and sexual functioning; anxiety about and lack of involvement in planning for future pregnancies; poor information exchange and communication (including both content and timing of discussions); poor emotional support from professionals and family members; physical and emotional impact; and unresolved anxieties in partners. Similarities occurred across both groups.* **Conclusions:** *A third-degree tear causes a significant emotional and psychological impact on women's physical and emotional well-being. We recommend that all staff receive adequate training to deal with the issues that may be raised. The provision of a dedicated, multidisciplinary team involved at an early stage to coordinate the repair and follow-up is recommended to allow a sensitive, consistent, evidence-based approach, particularly in terms of decision-making for subsequent births. The experiences and needs of partners require further study. (BIRTH 32:2 June 2005)*

The memories of childbirth can cause feelings of misunderstanding, guilt, anger, and confusion, which can lead to anxiety, depression, and even reluctance to consider future pregnancies (1,2). Childbirth is known to engender anxieties arising from feelings of loss of autonomy, lack of information, unexpected physical pain of childbirth, unexpected emotional reactions, and financial pressures (3,4). Between one fourth and one fifth of women suffer some form of postnatal depression, and between one third and one half have sexual difficulties (5,6). Other problems including fatigue, urinary incontinence, back pain, minor illnesses, dyspareunia, and relationship difficulties are also prevalent (7,8).

Third-degree anal sphincter tears are defined as partial or complete rupture of the anal sphincter muscles, and are an uncommon (0.5–2.0%) complication of vaginal delivery (9,10). Up to 50 percent of women will report anal incontinence several months after sustaining the injury (9–13). However, in contrast to childbirth *per se*, no qualitative studies have addressed the personal experiences of women with third-degree obstetric anal sphincter injury. Therefore,

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we undertook a qualitative study to explore these experiences during and after delivery of women who sustained this type of injury during childbirth.

Methods

Sample

We obtained a purposive sample of women who had attended a specialist perineal clinic based in a large teaching hospital in the United Kingdom. A purposive sampling strategy is defined as "a deliberate nonrandom method of sampling, which aims to sample a group of people, or setting, with a particular characteristic" (14). The exact sample size was determined by the number required to reach data saturation (i.e., focus groups would continue until no new data emerged). Women attending the perineal clinic were sent information by mail and were asked to indicate their willingness to participate in the study. Focus group 1 consisted of women who had sustained a third-degree tear in the index pregnancy. Focus group 2 consisted of women who had been delivered of a subsequent pregnancy after the pregnancy when the third-degree tear had been sustained. A third-degree tear was defined as any perineal laceration involving partial or complete rupture of the external anal sphincter, with or without associated rupture of the internal anal sphincter (15). Before the commencement of the study, full ethical approval was obtained from the local research ethics committee and NHS Hospital Trust research and development committee.

Data Collection

We considered that women may have been anxious to talk about their experiences of third-degree perineal tears, largely due to a feeling that no one else had suffered a similar injury. Since we thought that these feeling would make women unable to share their experience, we believed that, being a sensitive issue, it was best explored in small focus groups, where women would realize that theirs was not an isolated experience and be more able to discuss it.

Written informed consent was obtained before conducting the focus group. The interviews took place in a quiet room in the study hospital. Each focus group lasted approximately 90 minutes and was audiotaped. A broad interview schedule was developed with content validity being gained through review of previous literature, clinical experience, and multi-professional discussions. However, much of the detailed discussions were respondent led. Information on demographic and delivery details were collated from hospital records. The lead investigator (AW) facilitated all the focus groups.

Data Analysis

The audiotapes were transcribed verbatim and then entered onto a word processing package. Pseudonyms were given for each participant. Analysis was undertaken using an open coding mechanism to identify emergent themes, in a process similar to grounded theory analysis (16). The interactions among participants was observed and noted. Axial coding was used among participants to look for diversity and commonalties. However, being a homogeneous group, responses were fairly consistent.

Two researchers (AW and TL) independently generated themes from the responses to minimize interpreter bias. These were then collated and individually discussed until a consensus was reached. To further increase confidence in the validity of the findings, all participants were sent a summary of the discussions of the focus group to confirm the accuracy of the interpretation.

Results

Nineteen women were approached to join focus group 1, and 14 women to join group 2. Since 23 women declined participation, group 1 had 6 participants (median age 31.5 yr) and group 2 had 4 participants (median age 32 yr). All women were Caucasian. The details of participants, including symptoms at the time of the study are outlined in Tables 1 and 2. No woman had anal incontinence.

Common themes were identified between the two focus groups (FG1 and FG2), with an additional theme of "involvement with decision-making for future delivery," which was relevant only to group 2. We have therefore presented the data as one cohort. The primary themes identified are summarized below.

Apprehension

Participants verbalized their apprehension, particularly in relation to subsequent births. For example, one woman said:

> But I am really worried about this one. I said to my midwife you know I am a bit apprehensive about it and don't know which way to go. And she said the decision is up to you if it's a big baby, if you are measuring bigger than you were with Luke I'd opt for a cesarean. It wasn't until I came here for my 5 months' scan and I spoke to, I can't remember who I spoke to, but they said the way they are edging towards is to go for the natural delivery with an episiotomy so I am in two minds and I am thinking I don't want to have a

> cesarean if I don't need one, but I will try and do it naturally. (FG2, participant 2)

It appeared that, in some cases, health professionals compounded this apprehension by inappropriate comments:

> I felt very apprehensive because one midwife actually said to me you are having an elephant!. . . . So he was a lot bigger, and when I got told that I remember going home crying because I just thought the problems I had with him, how am I going to manage? They won't be able to get it out, I was petrified. I actually wanted a cesarean that I was glad I didn't have. (FG2, participant 3)

Information-seeking behavior demonstrated during the focus groups suggested that women were unsure of the future consequences of having a third-degree tear. Yet the fear of a repeat tear was highlighted as an integral part of the anxiety they were experiencing:

> Once we have had a tear, can we have a natural birth again and what's the chances of it happening again? (FG1, participant 5)

> What would be my chances if I went into labor and they said, do we do an episiotomy or shall we leave you what? (FG2, participant 2)

Information/Communication

All women who participated in the study made some comments about timing and content of the information that they received about third-degree tears. Furthermore, the way in which this information was communicated was also a pivotal issue for participants. The timing of information after the birth was crucial to women's understanding of this outcome. Yet, for some women, there appeared to be a delay in appropriate information being communicated to them. For example, one woman said:

> Even 3 days later I didn't know I had had a third-degree tear until 3 days later when the midwife come and told me. (FG1, participant 3)

Another said:

> And at the time when it happened, I didn't understand what it was because I felt out of it after having my baby. I did not understand. Even if I had asked questions I couldn't have remembered what was being said, and all I knew was I was away from my baby and I thought well perhaps I ought to be with my baby. (FG1, participant 2)

When information was provided, it was sometimes communicated in a very rushed way:

> Well, all the midwives seemed, they just seemed so busy, it's just as if they need to double up the amount of staff because they were just so busy and they haven't really got time to sit with you and discuss things, and I just think there was a serious lack of communication. (FG1, participant 1)

The women thought that their expectations were often unfulfilled in terms of their questions being answered by those providing care. The perceived reticence to supply information projected health

Table 1. Participants' Profile for Focus Group 1 (No Subsequent Delivery After Injury)

Participant	*Age (yr)**	*Mode of Delivery†*	*Birthweight (g)†*	*Months Since Delivery†*	*Parity†*	*Marital Status**	*Symptoms**
1	29	Spontaneous vaginal	3,054	7.5	0	Married	Dyspareunia
2	32	Ventouse	3,905	21	0	Married	Dyspareunia
3	31	Spontaneous vaginal	3,560	11	0	Single	Urinary incontinence
4	35	Spontaneous vaginal	3,005	7	1	Married	Urinary incontinence
5	27	Forceps	3,246	14	0	Single	Dyspareunia
6	32	Ventouse	3,643	13	0	Married	None

**At time of study.*
†Data refer to the pregnancy in which the injury occurred.

Table 2. Participants' Profile for Focus Group 2 (Subsequent Delivery After Injury)

Participant	*Age (yr)**	*Mode of Delivery†*	*Birthweight (g)†*	*Months Since Delivery†*	*Parity†*	*Marital Status**	*Symptoms**
1	32	Ventouse	3,656	42	0	Married	Urinary incontinence
2	29	Spontaneous vaginal	2,850	36	0	Married	None
3	37	Forceps	3,648	30	0	Married	Dyspareunia
4	32	Spontaneous vaginal	3,578	32	0	Married	Urinary incontinence

**At time of study.*
†Data refer to the pregnancy in which the injury occurred.

professionals in an unfavorable light and suggested a lack of knowledge:

> With everyone I asked—midwives, doctors—it was almost like they don't want to commit themselves to facts or, you know, all very vague. I was wanting information and help, and no one ever really seemed to know. (FG2, participant 2)

Women appeared shocked at the perceived lack of knowledge held by some practitioners:

> I was surprised that your doctor (GP) doesn't sort of know anything. (FG1, participant 1)

Participants expressed the need for information to be provided in a visual way. Some women suggested an "information sheet about third-degree tears would be useful," because this would allow the information to be absorbed more easily. Several study women commented positively about the information provided in the perineal clinic, and made particular reference to anatomical models that were used:

> I wasn't listening because I am just thinking I have got to get back to the baby and then I came here. It was when you showed me the model, even though you had explained it to me because I am thinking that you explaining it to me when it is happening is no good to me anyway, but when I came in it's like there's the model, that's what's happened and you go, "oh no!" (FG1, participant 5)

Support

Women made regular reference to the lack of support available from both health professionals and significant others. Participants expressed their desire to have their feelings heard, as highlighted by this woman:

> I knew it wasn't right, but there was nobody. I kept saying to people "it's not right, it's not right," and it just wasn't registering with anybody. And it wasn't until 2 weeks later when I went to my GP and said, "look this isn't right" and he said, "yeah, you're right, it's not." But if there had been somebody there for me to speak to, some kind of counselor or someone like that, just specifically for this type of problem, I would have come away with all the facts, somebody to call when I got home. (FG1, participant 1)

Several women also expressed feelings of isolation:

> I felt like I needed a bit more support after it. I felt like, you know, what's happened has happened, and at the end of the day get on with it, but then I felt like I was alone, and I didn't know anyone else who had had one. (FG2, participant 2)

For some women the study focus groups had provided them with the first opportunity to discuss their views and experiences. Clearly, the participants found this a therapeutic experience:

> I think being part of the study has really helped me.... It reassured me. (FG1, participant 1)

In some cases it was only after attending the perineal clinic at 6 weeks, then at 3 months postnatally, and when required subsequently that women were given reassurance about future recovery:

> It (perineal clinic) reassured me because I thought I would never be the same ever again.... (FG1, participant 5)

The perineal clinic was generally viewed as a supportive environment, and women felt confident about the information provided by the staff working there:

> ... But what I am saying is going to the doctors and saying, "I've got this third-degree tear," and they're, like, "right, OK," whereas you deal with [it], that's what you specialize in. I feel a lot confident and like I am getting the same information once I come to the clinic. (FG1, participant 5)

Support from significant others was often lacking. Although women stated that "talking about it helped," in some cases the partner distanced himself from the problem, perhaps believing it was not part of his domain:

> He was no good. He was going, "I don't want to know all about that." He wasn't any help at all. (FG1, participant 5)

Another said:

> Well, mine's not because mine just goes "oh, I don't need to know all about that jazz," and you want to talk to him about it, but ... it's not that he's a prude. (FG1, participant 4)

Physical Impact

As perhaps anticipated, women had concerns about the state of their perineum. They were also worried about the impact that the third-degree tear had on their bladder and bowel function. For, example, one woman said

> That was the scary bit, it was going to the toilet. (FG1, participant 5)

Another said:

> My problem, as well, is after having the third-degree tear, my pelvic floor was just nonexistent, and every time I felt like attempting anything I felt like I was going to wee myself. Or if he attempted anything, it was just a "no go area," if you know what I mean either way. (FG1, participant 4)

Another woman described her anxieties:

> I think that's what [it] is with me—I am scared my bladder is going to go more than ... the back passage seems OK; it's more my bladder that I am self-conscious about. (FG1, participant 5)

Some women described the pain that they were experiencing and the repercussions of the physical trauma:

> But because I have been stitched up sometimes I don't know whether I have wet myself or what, but when I have sex it hurts. (FG1, participant 3)

Emotional Impact

The huge impact of a third-degree tear on women's emotions was apparent throughout the focus groups, as indicated by the words spoken as well as the body language demonstrated:

> I think I was really bad actually, and I don't want to get upset now! (sobbing). (FG1, participant 2)

However, it appeared that women's initial perception of the tear was one of indifference, since they believed that it was a "'normal" consequence of having a baby.

> Yeah, it was just part of having a baby I thought. (FG2, participant 1)

> It was just a big tear isn't it! (FG2, participant 4)

> I was, like, what is the concern, what's all the fuss about? (FG2, participant 3)

Professional perceptions of the impact of a third-degree tear were often relayed to the women, whose concerns of potential consequences of a third-degree tear appeared to be initiated and/or highlighted by comments from members of staff:

> . . . It was more the midwife and the health visitor saying, "oh, you have had a third-degree tear," as if I have had this big major thing. And I was OK about it. So it was more other people saying things like that to me. (FG2, participant 2)

> I had people like the midwives and Dr. X saying, "God, you have had a third-degree tear! (FG2, participant 3)

One woman articulated the views of other participants in her account of the realization of what had occurred:

> It didn't bother me at first because I didn't know what it was. I just thought it was just a little tear until the midwife came and sat me down and told me exactly what it was, then I got a bit scared. I started crying. (FG1, participant 1)

Once women had been told of the third-degree tear, their perceptions of their body image altered.

> I couldn't bear to see it. I couldn't bear to touch it. I couldn't bear anything. (FG1, participant 2)

> . . . When I was talking to my husband, I sort of felt as though I didn't want him to think I was, like, underneath was all messed up. (FG1, participant 3)

However, women's anticipation of what their perineum would look like was sometimes unsubstantiated, as demonstrated in this quote:

> It took me about 6 weeks, and then I thought I have got to have a look, and I was surprised it wasn't as bad as I thought. (FG1, participant 5)

For some women, recovery took longer than anticipated:

> It took a good year before I felt like my body. I felt horrible and felt baggy and horrible, but then after a year it went back to normal, and I just probably started having sex. (FG1, participant 3)

Sexual Relationships

The impact of the third-degree tear on sexual relationships was a major area of concern for women. Concerns centered on the initial resumption of sexual activity and whether intercourse would hurt:

> Well, actually, I was worried about the first time because I was thinking, oh, it really hurts after the third-degree tear. (FG2, participant 3)

But women were also concerned about the potential lack of sensation:

> It's what I was worried about, you know—what if I get no sensation or anything like that? (FG1, participant 1)

Some women dealt with their anxieties by sexual avoidance:

> It's more me. I don't go near him any more. He says the best form of contraceptive is having a baby, yeah that's what he says. I said to him the other day, "it's not because I don't love you anymore, it's just that I can't bring myself to do it. (FG1, participant 2)

Whereas other women just pretended to their partners that there wasn't an issue:

> He keeps saying to me, "Are you OK, you OK, you all right, you all right?" Yeah, I'm not like . . . but "yeah, I'm fine." (FG1, participant 4)

> It hurt a little bit. Yeah, it was just uncomfortable at times. But it didn't have any negative impact on him. (FG2, participant 3)

When partners did show women some concern, the women suggested that this altered the sexual chemistry, which then resulted in sexual indifference.

> I think that's why you start losing your libido because whilst you are attempting it they are going, "Are you OK?" and you go, "I can't be bothered." (FG1, participant 5)

The partners themselves had demonstrated anxieties, as suggested by this woman:

> They [partner] sort of feel that they have got to be careful, I think. My husband says "I'm frightened because you are tense," [but] you can't help it. (FG1, participant 3)

Lack of Involvement in Decision for Subsequent Delivery

From women's conversations during the focus groups, little was said about the mode of delivery for a subsequent birth.

> Well, I didn't really get any advice either way. Actually, I would like some advice on my options. (FG2, participant 2)

Those who did discuss birth options suggested a degree of bias toward having a cesarean section. For example,

> But you know if you want a cesarean. They [health professionals] did put that in my head, and I said "no." (FG2, participant 3)

Another said:

> I don't know who it was who I spoke to asking if I could have a vaginal delivery again, and they said "No, you probably would have to have a section." (FG1, participant 2)

Another woman said:

> The doctor sort of said to me it was up to me, but started saying that I've healed OK after the third-degree from last time, [but] I might not heal this time and all the bad points if I hadn't healed. That's when I said cesarean, and that's my biggest regret. (FG2, participant 1)

Discussion and Conclusions

This small qualitative study examined the emotional and social impact of obstetric anal sphincter injury. An extensive literature exists on the physical consequences, demonstrating that between 30 and 50 percent of women suffer from fecal incontinence, urgency, dyspareunia, or perineal pain, which may persist for several years after primary repair (9–12, 17,18).

Initially our study was intended to analyze the data from women who were pregnant again after sustaining the third-degree tear separately from those who were not pregnant, but the emergence of common themes rendered this distinction a false one. The commonality of themes also reinforced the validity of study data, despite the small number of respondents.

We chose to use focus groups to collect data for this study because we believed it would be the most appropriate method to gain an insight into the experiences of women after an obstetric anal sphincter injury. The main advantages of a focus group are that it encourages participants to generate and explore their own questions and to develop their own analysis of common experiences. This was certainly the case in this study, and it also encouraged open conversation about embarrassing issues that otherwise would not be revealed. Women clearly found the focus groups therapeutic, which was evident from their comments as well as the depth of information supplied, thus confirming that the appropriate method of data collection was used.

It most be borne in mind that, despite perceived advantages of a focus group, there are some drawbacks. First, the internal dynamics within the group can generate contrasting effects. The censoring or conforming activity of groups when individuals, in response to their perception of others and other members' views, adjust or withhold their contribution was described by Carey (19). However, we did not detect any suggestion of such a process within our sample, although this does not necessarily rule it out entirely.

Our findings identified areas where the existing standards of care do not provide adequate (if any) support for the issues raised. It is clear that the experience of third-degree tear generated significant emotional and psychological distress, which were not fully identified or resolved for the women we sampled. Many themes may be seen to interact in several directions simultaneously.

Anxiety and apprehension were apparent in many areas: risk of further injury after subsequent delivery, physical consequences of the injury, and resumption of sexual intercourse. These anxieties may have been compounded by the identified deficiencies in information giving. Women found both the timing and content of the information they received to be inadequate or inappropriate, and lack of accurate and adequate information would almost certainly have contributed to their anxiety. For instance, apprehension about mode of delivery in a subsequent pregnancy was generated by fear of further injury in the absence of adequate discussion of known risks, and compounded by inappropriate comments from staff about the size of the baby. The situation is likely also to have been compounded by feelings of isolation that women reported. They felt isolated from health care professionals, partners and other family members, and also other women, which can be clearly seen

in the value that women attached to attending the focus groups and discussing their injuries with other women.

Feelings of isolation from partners were described in terms of unwillingness to discuss the matter, or excessive concern about discomfort during intercourse. Bearing in mind the anxiety and isolation which the women felt, it seems highly likely that partners also felt the same emotions and therefore had the same needs for discussion, support, and information.

Thus it appears that lack of information and poor communication were the most important components of women's unmet needs. Although there was often an inappropriate display of sympathy for the woman, the provision of accurate, sensitive information was limited. Oral information alone was not considered to be adequate. Visualization of the perineum through use of models was important because participants were unfamiliar with anatomy and physiology of that area of the body.

These themes echo the findings of others, when loss of control, physical pain, emotional and sexual difficulties, and lack of information were the source of anxiety after childbirth of any form (5–8). This commonality reinforces the validity of our findings, but the specific intensity of feeling we have identified may relate to the women's perceiving a greater significance of the consequences of the injury sustained.

We acknowledge the bias that may have been introduced by the principal investigator being both the interviewer in the study and caregiver in the clinic, but we believe that the positive relationship that had developed encouraged study women to speak openly and freely. This was evident from their willingness to disclose very intimate details. In keeping with qualitative methodology, the findings were not intended to be generalizable; however, they are likely to have applicability to similar women, in similar settings.

On the basis of this study we can tentatively make some recommendations for change in practice and for further study. The issue of the timing and amount of information to be given to women who suffer a third-degree tear needs to be addressed. This obstetric complication occurs in the midst of a highly emotionally demanding event in a woman's life, and other emotions (e.g., of new motherhood, concern for the infant) will necessarily be in potential conflict with the need to adequately inform the woman of what has occurred. It is therefore essential that all professionals involved in the care of women in labor have accurate knowledge of the recommended practice for repair of these injuries (15). It is likely that repetition of important information will be required to ensure that adequate understanding is achieved. From our experience the provision of a dedicated team for the counseling and follow-up of all women who suffer a third-degree tear would seem to be the necessary minimum standard. We would recommend that this team be involved at an early stage in the care of every woman who suffers such a tear to ensure continuity of care and to facilitate the establishment of the necessary degree of trust.

We would also recommend that the counseling and follow-up arrangements should actively involve and support the woman's partner so that he will be able to offer emotional support, and also address his own anxieties. The emotional and information needs of the partners of women with anal sphincter tears are a topic that would benefit from further research.

In conclusion, we have identified a range of previously unrecognized emotional consequences of obstetric anal sphincter injury that seem to arise as a consequence of inadequate or inappropriate information exchange. The provision of a team of staff skilled in dealing with these women appears to be important, but further work is required to examine whether the recommendations we have made do, in fact, influence the emotional and psychological outcome.

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