Commentary. The impact of severe perineal trauma on a woman's relationship with her child: a hidden consequence

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The incidence of obstetric anal sphincter injuries (OASI) during a first vaginal birth is increasing [1,2], the rise potentially attributable to better identification of injuries by clinicians and changes in practice, for example through national quality improvement initiatives [3, 4]. OASI is the most severe form of birth-related perineal trauma, with injuries to the pelvic floor and innervation of the anal sphincters and levator ani potentially even more common [5]. What is clear is that the consequences of these injuries for a woman, such as anal incontinence and genital prolapse in later life, can be devastating [6]. A recent systematic review of non-invasive modalities used to detect women with symptoms of anal incontinence including after OASI, found at least 20% of women who had given birth in the previous five years had symptoms [7]. Of note is that the incidence and prevalence of anal incontinence symptoms are likely to increase with maternal age [8].

Few studies have considered impacts of anal incontinence on a woman's quality of life but studies which have asked women about impacts report devastating social and psychological consequences, including isolation, shame and suffering an 'unspoken taboo' [9]. Maternal mental health problems including depression are common following birth [10] with evidence from one recent study that primiparous women identified as less 'resilient' to coping with life's adversities had an increased risk of depression at six weeks postpartum following OASI [11]. Symptoms of post-traumatic stress disorder (PTSD) [12, 13] have also been reported following OASI, the severity of PTSD related to extent of perineal injury sustained [14, 15]. It is not surprising that women suffering PTSD may also report a compromised relationship with their child and their partner [16,17,18,19] and that in some cases, mental health trauma is so significant a woman may not want to experience pregnancy again [20, 21].

Although a damaged maternal-infant relationship is recognised among women suffering mental health problems [10], little attention has been paid to the impacts of physical birth injury, such as OASI on how a woman perceives her relationship with her child. To inform a future research programme for MASIC, a UK-based charity which supports women who experience severe perineal trauma (www.MASIC.org.uk), an online survey was distributed via social media networks to ask women about the impacts of severe perineal injury (OASI) on their emotional and physical relationship with their child. All responses were anonymous and no information was collected on women's obstetric history

or other personal details, other than the age range they belonged to. For each included question women were asked to select a response from options offered and could provide additional information to support their response if they wanted to.

The survey was advertised online via MASIC social media platforms during a one-month period (January 2021) with responses received from 325 women. Respondents were aged from 18-74 years of age, the majority (89%) aged between 25-44 years.

Results highlighted not only the impacts of OASI on women's relationships with their child, but the duration of this impact. Only 47 (14%) women reported that their perineal injury had had no apparent influence on the relationship with their child. Of the 278 (85%) women who considered their injury had affected their relationship, for some the impact was relatively short-term: 129 (40%) said the impact did not exceed six months, however for others, it persisted, with 87 (27%) women saying the relationship impact persisted for at least a year, and 57 (18%) that it lasted for at least five years. Forty-six women (14%) reported that they felt that their relationship with their child was irrevocably damaged.

When asked how their perineal injury affected their relationship with their child, most (220/78%) women said that physical pain from the injury compromised their relationship. As one woman wrote:

I believe I never bonded with my child because of the injuries, not being able to move/take her out of the crib for the first few days, because of the pain I was in.

Emotional and psychological effects were significant with half of women (138/49%) doubting their ability to 'mother' due to the injury. Around half of the women 147 (52%) reported their relationship with their child had been damaged due to embarrassment about their symptoms and need to urgently access toilet facilities; 143 (51%) women said their injury affected their ability to take their child to school or nursery or to social/sporting activities.

Women's responses to being asked about the impact of their injury on aspects of caring for their child, for example breastfeeding, highlighted widespread impacts. A third of women reported that their injuries impacted on their ability to breastfeed, with some unable to breastfeed at all or having to stop before they had planned to due to pain from their perineal injury. When describing this, one woman wrote:

I was in so much pain I was unable to even change his nappy for two weeks. I had to give up breastfeeding due to pain which made me feel like an awful mother. He weighed 10lbs at birth and I felt like his weight (and therefore he) was responsible for my trauma.

Of concern was that in some cases, women described more persistent consequences for their child's well-being, such as their child being isolated from others as the woman was unable to leave the house because of needing access to toilet facilities, as in the following case:

My child was completely isolated as a result of my injury and did not meet other children until school.

In one case a woman described how their child had been bullied at school because the child's peer group knew of the woman's injury.

My child has been bullied as a result of school friends noticing symptoms of my injury and this has continued into secondary school.

Mental health problems were common; 126 (45%) women identified postnatal depression as profoundly affecting their relationship with their child; 96 (34%) women said that blaming the child for the cause of their injury resulted in a barrier to their relationship with them. Eighty-six (30%) women said the relationship was so damaged they wondered if their child would be better off without them; 69 (24%) women expressed regret over ever having had a child.

Our survey was a 'snapshot' of a self-selected sample of UK women who suffered severe perineal trauma. The sample size is small and unlikely to be representative, and data on women's characteristics and their obstetric history were not collected. Some women may have felt more empowered to respond and comment in an online survey rather than a face-to-face interview, but conversely as data were collected during the height of the UK COVID-19 pandemic, some responses may have been heightened due to anxiety about the pandemic.

Despite limitations, findings highlight important but under-researched impacts of OASI for a woman and her child which need urgent attention. The bond between the woman and her child is fundamental to the child's development. The early years concept of support, dependence and caring for the physical and emotional welfare of a child is precious in all societies, independent of situation, privilege and circumstance [22]. Although the impact of a woman's emotional health on the mother-infant relationship is well recognised [18], the influence of physical injury on this relationship has hitherto been neglected.

Pain was the prominent physical issue reported by respondents, and a particular problem in women with OASI especially if repairs become infected or there is significant scar tissue. A more debilitating, protracted and neglected cause of pain is pudendal neuropathy following prolonged labour, poor labour progress, excessive pushing and/or forceful traction at assisted vaginal delivery [23]. These injuries are not necessarily confined to the pudendal nerve and can affect the sacral plexus, with pain referred beyond the perineum, leading to hyperaesthesia of the vulva and anal margin and sensory disturbance and awareness in the bladder, anorectum and vagina, resulting in incontinence and sexual dysfunction [24].

Physical barriers to the relationship with the child arose from embarrassment of being unable to control flatus and faecal urgency, having to dash to the toilet and being toilet dependant, barriers reported in general population studies [25]. Women with anal incontinence interviewed in previous studies described feeling unable to leave the security of their home leading to isolation, fear of meeting with others, lack of confidence, and coping with a condition too embarrassing to discuss with others [26, 27, 28]. The consequences of these distressing symptoms when eventually discussed with a clinician is that women may be sent for investigations which are often intrusive, time consuming and require repeated hospital visits. In some cases, surgery to resolve problems may be attended by complications and not always (especially in the case of fistula) successful [29].

Separation of the physical from the emotional impacts of OASI is not appropriate in the context of a woman's relationship with her child, with emotional barriers such as PTSD commonly reported in our survey and a recognised cause of a disrupted relationship [16]. Birth memories do not fade and the child's birthdays are repetitively painful experiences which many women come to dread. Isolation and embarrassment, already been referred to amongst the woman with anal incontinence [9,10] were identified as common factors for damaged relationships.

Compromised relationship issues following severe birth injury is complex. The relationship a woman has with her partner is key; some partners may not understand the issues including why sexual relationships may be fractured or how a woman is having to manage her health following anal

sphincter injury. In other cases, the relationship with the partner changes, with the partner having to take on more of the care of the woman and/or the child. There are also wider family impacts as a woman's close family often do not understand how birth injury has impacted on her life. This is even more complicated if women in some communities' fear that if their condition is discovered they could become an outcast [30].

Perhaps the most distressing finding is that women expressed a sense of failure as a mother, a finding reported previously [9] and in some cases, blamed their child who then becomes the unheard observer of a damaged family unit and a victim of it. As these injuries predominantly occur with a first birth, women may be reluctant to have more children [31].

Some injuries may be prevented by active perineal protection at birth [3] and avoiding assisted vaginal delivery when safe to do so [32]. Better detection of the injury at the time allows immediate repair by clinicians mentored and trained to repair third and fourth degree tears, with better outcomes for bowel function in the shorter-term [33]. There is a need for women to have access to much better information about the risk of these injuries and their consequences, especially after the Montgomery legal ruling in the UK [34] although worrying that little progress appears to have been made on provision of maternal choice [35]. Women must be given choice especially in cases such as the woman with a high BMI with gestational diabetes and other comorbidities that place her at higher risk of injury [36]. Previous reluctance to accept that women need to make choices that affect their birth outcomes [35, 37], particularly during a first pregnancy when risks of injury are much greater may shift, given a recent recommendation to NHS England that limits on offering planned caesarean birth should be removed in response to the ongoing maternity review at the Shrewsbury and Telford NHS Trust [38].

The relationship between a woman and her child is fundamental and pivotal to the child's development. This relationship could be badly damaged by a severe perineal injury and every effort should be made to prevent these injuries. When injuries do occur, as inevitably they will despite the best care available, appropriate support should be provided which takes account of the woman-child relationship in addition to repair of the physical injury.

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