

**LEAD MATERNITY CARE MIDWIVES' PERSPECTIVES ON THE EFFECT OF SEVERE  
PERINEAL TRAUMA ON THEIR RELATIONSHIP WITH WOMEN**

By

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## ABSTRACT

Although childbirth is a time of happiness and joy for couples, happiness can be flawed by pain and discomfort associated with perineal trauma sustained during childbirth. It is estimated that 85% of vaginal births are accompanied by trauma to the perineum. A higher risk of trauma is sustained at the first birth compared with subsequent vaginal births. In New Zealand, midwives work in partnership with the woman. The Lead Maternity Care (LMC) midwife has an ongoing relationship with the woman in her care that starts when the pregnant woman books with the midwife and ends at six weeks postpartum. The relationship between the woman and the LMC midwife involves trust, shared control, responsibility and a shared meaning through mutual understanding. Midwives fear they will be held responsible by women who sustain severe perineal trauma during their birth for the outcome. There is a lack of research into how New Zealand midwives' relationships are affected when women in their care sustain severe perineal trauma. This research sought to explore the experiences of LMC midwives who have cared for women who sustained severe perineal trauma during childbirth. The objective of this study was to understand the effects of severe perineal trauma on the midwife/ woman relationship. The aim was to explore LMC midwives' perception of how they were affected when women in their care sustained severe genital tract trauma during birth. Qualitative descriptive methodology was used. Face-to-face semi-structured interviews were conducted with LMC midwives from three geographical regions in lower North Island of New Zealand. The participants were eight midwives who had personal experience of caring for a woman who sustained severe genital tract trauma during childbirth. The findings revealed three themes: building a relationship with women, participants' perceptions of the effects of severe perineal trauma on women, and the impact of severe perineal trauma on the midwife. The findings demonstrate that LMC midwives build relationships with women during the antenatal period. This relationship ensures an excellent partnership, established on the foundation of trust and respect, developed with the women. Midwives are affected on a personal and professional level when woman sustains trauma during childbirth, and the midwife adopts ways of coping. In the aftermath of severe perineal trauma, the woman may suffer health problems. This can impact her relationship with her LMC midwife during the postnatal period.

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Nga Maia o Aotearoa  
Maori Midwives



Audrene Samuel

Midwifery Research Proposal

July 2<sup>nd</sup> 2018;

Tena Koe Audrene;

**RE: Audrene Samuel- Approval and Feedback- Research proposal Maori Health Consultation**

Thank you for submitting to Nga Maia Maori Midwives representative, a copy of your research proposal, intended questionnaire and describing your research method on your chosen topic;

**What are the effects on the LMC Midwife/Woman Relationship when the women sustain severe perineal trauma during childbirth?**

You have outlined your research methodology which maintains the 'confidentiality' and 'anonymity' of both the midwife and woman participant.

Your research findings will have significant implications for Midwifery Practice.

**Recommendations**

1. **Maori participation-** It is important that Maori representation is considered. The study findings should reflect the proportion of Maori midwives whom participate in your research ensuring 'confidentiality and anonymity'
2. **Maori midwifery perspective-** It is important that any research protects Maori cultural interests, promotes Maori wellbeing and provides mechanisms for Maori participation, in order to give effect to the Treaty of Waitangi. Therefore, Maori midwives should review and confirm questions and answers to ensure their responses are appropriate from their Maori perspective.

**Declaration by Nga Maia Maori Midwives**

Your application is hereby endorsed and supported with consideration of the recommendations outlined.

Nga mihi

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## CHAPTER ONE: INTRODUCTION

### 1.0 Introduction

The underlying philosophical approach of New Zealand (NZ) midwifery is one of partnership. The midwife attempts work in partnership with the woman in her care during the antenatal period, labour and birth till six weeks postpartum. This partnership between the midwife and the woman in her care is based on respect (Pairman, 1998). A positive birth experience may impact on the future well-being of the mother and her relationship with her infant (Halldorsdottir & Karldorsdottir, 2011). The woman's birth experience may also influence her relationship with her midwife. For women, the happiness of childbirth can be marred by discomfort associated with severe perineal trauma (Soong & Barnes, 2005). These injuries may result in long term morbidity for these women.

Midwives consider their relationship with childbearing as core to their job satisfaction (McAra- Couper et al., 2014). They regard this relationship as the embodiment of midwifery care (Kirkham, 2007). Midwives experience feelings of guilt when women in their care sustain severe perineal trauma (SPT) during childbirth and fear the women may blame them for these injuries (Dahlen & Caplice, 2014). A qualitative descriptive exploratory research method was chosen to determine LMC midwives' perspective on the effects of severe perineal tear, sustained during childbirth on their relationship with the woman during the postnatal period.

### 1.1 Background

Perineal trauma sustained during childbirth is not a new phenomenon. Historical literature from 2500 BC to 1900 AD confirm women have experienced perineal injuries throughout the centuries (Dudley, Kettle, Waterfield & Ismail, 2017). Perineal trauma remains one of the most common complications of childbirth, and millions of women worldwide continue to sustain various degrees of perineal trauma following childbirth (Dudley et al., 2017). The degree of morbidity, experienced by affected women during the postnatal period, is related to the extent and complexity of genital tract trauma. The complications of SPT have the potential to change the quality of the affected woman's life (Albers et al., 2005). Thus, woman may perceive this event as traumatic. Any traumatic event in the childbearing woman may potentially harm the LMC midwife (Calvert & Benn, 2015). Severe perineal trauma sustained by a woman has the potential to impact the ongoing relationship between the LMC midwife and the woman during the postnatal period.

### 1.1.2 What is severe perineal trauma

Severe perineal trauma occurs to the perineum when a tear extends to the anal sphincter complex (Royal College of Obstetricians and Gynaecologists [RCOG], 2015) during childbirth. The perineum combines the diamond-shaped area stretching from the pubic arch to the coccyx. The perineum is subdivided into the anterior (urogenital) and posterior (anal triangle) sections (Patton & Thibodeau, 2010). Severe perineal trauma injury occurs to the perineum when trauma extends to the anal sphincter complex (RCOG, 2015). Perineal tears are categorised as follows:

- First-degree perineal tear is a tear to perineal skin only
- Second-degree perineal tears involve injury to perineal skin and muscle but not the anal sphincter
- Third degree perineal tears involve injury to the perineal skin and muscle and include the anal sphincter complex. Third-degree perineal tears are further classified into subgroups:
  - 3 (A): Tear involving less than 50% of external anal sphincter (EAS) thickness
  - 3 (B): Tear involving more than 50% of EAS thickness
  - 3 (C): Both external and internal anal sphincter (IAS) tear.
- Fourth-degree tears involve an injury to perineum muscle and include both internal sphincter (IAS) and external anal sphincter (EAS) complex and the anorectal muscles (RCOG, 2015).

As perineal tears affect the anal sphincter muscles, they can result in significant morbidity. They can be a contributing factor to long term health problems for some women who may suffer a consequence of SPT (D'Souza, Monga & Tincello, 2019). There are several risk factors for SPT and these are described below.

### 1.1.3 Risk factors for severe perineal trauma

The perineum is physiologically designed to stretch and flatten during the birth process, allows the passage of the baby without any harm. Perineal trauma arises when the perineum tears during childbirth. It can occur spontaneously or as a result of obstetric intervention during vaginal birth (Dahlen et al., 2013). For example, it can occur when an episiotomy is performed during the delivery of the fetal head (RCOG, 2015). The RCOG (2015) indicate several risk factors for SPT. These risk factors include: Asian ethnicity, first vaginal birth, birthweight greater than 4 kilograms (kg), shoulder dystocia, baby in occipital-posterior position, prolonged second stage of labour with a duration of the second stage between 2 and 3 hours, epidural analgesia, episiotomy, and assisted vaginal birth (ventouse extraction or forceps delivery) with or without an episiotomy. Women in New Zealand are not immune to perineal trauma.

### 1.1.4 Incidence of perineal trauma in New Zealand

The NZ Maternity Clinical Indicators for 2017 include statistics on the incidence of perineal trauma sustained by primigravida women (Ministry of Health [MOH], 2019). In 2017 there were 59 640 live births in NZ. A total of 7491 vaginal births were to women who identified as primigravida (MOH, 2019).

**Table 1. Incidence of perineal trauma in New Zealand primigravida women\***

Perineum	Total number of women	Percentage of total births
Intact perineum	2078	27.7%
SPT.	326	4.4%
No episiotomy performed		
No SPT.	1838	24.5%
Episiotomy performed		

Source: Ministry of Health (2019). New Zealand Maternity Clinical Indicators 2017.

## 1.3 How women are affected by SPT

The ongoing health and well-being of new mothers are negatively affected by perineal trauma, in some instances, for a long time (Albers et al., 2005). The degree of morbidity experienced postnatally is related to the extent and complexity of genital tract trauma (Albers et al., 2005). Some women may be asymptomatic, while other women experience any or all of the following symptoms.

Ongoing pain may negatively impact daily activities and family functioning (Brown & Lumley, 1998). Pain and swelling in the perineal area may adversely affect the woman's ability to walk, sit, breastfeed and bond with her infant (Brown & Lumley, 1998). Perineal pain and discomfort may also cause dyspareunia and interference with sexual activity. SPT weakens the pelvic floor muscles; therefore, bowel, urinary, and sexual function after childbirth may be adversely affected. Urinary and bowel dysfunction include symptoms such as stress or urge urinary and faecal incontinence (Glazener et al., 1997). These women are at risk of developing co-morbidities, including prolapse of the pelvic organs and vesicovaginal fistulas (Brown & Lumley, 1998). Other symptoms include haematomas and haemorrhoids (Fernando, Sultan & Kettle, 2007). These physical health problems may harm a woman's psychological well-being.

The multi-dimensional physical and psychosocial impact and the difficulties faced by affected women vary. The women often feel broken and see themselves as a failure. They can also experience feelings of being devalued, disregarded and dismissed. The physical and psychological outcomes for these women can be complicated as many feel isolated and not taken seriously by health professionals when they report ongoing pain and discomfort (Priddis et al., 2012). Ongoing consequences, such as severe pain, often transform the woman's perception of herself (Albers et al., 2005). The woman may also question the role her midwife played in the injury sustained at birth and reflect on how her LMC midwife supported her.

Levels of compassion and companionship that women did or did not feel during labour and birth are known to impact on how they reflect upon and dealt with their experience of SPT (Priddis et al., 2012). Many women who sustain SPT during birth may focus on how they were treated by their midwife during labour, birth, suturing process and the postpartum period. Medical interventions have an impact on how parents experience the birth of their child (Lundgren, 2004). Any event seen as negative or traumatic during labour and birth can lead to an extreme fear of future childbirth. These events may cause women to give birth to fewer children or extend the time interval to the next child (Gottvall & Waldenström, 2002). A negative birth experience could also be related to the desire for caesarean section during the later delivery (Lindberg et al., 2013). Support, particularly from midwives, is crucial to ensure a woman has a favourable view of her birth (Halldorsdottir & Karlsdottir, 2011). A woman's perception that her LMC midwife did not provide adequate levels of support during her labour and childbirth is a risk factor for developing post-traumatic stress disorder (Olde et al., 2006). It is problematic to predict tears in individual women, and midwifery practises can do little to prevent them. Therefore, the focus should be on the LMC midwife who conducts the birth to recognise perineal tears (Byrd et al., 2005). The model of care, levels of compassion and companionship that women perceive to have received from their midwives during labour and birth can impact on how they reflected upon and dealt with their experience of SPT (Lundgren, 2004).

## 1.4 The New Zealand model of midwifery care

New Zealand has a unique LMC midwifery model of practice that is a source of pride for both women and midwives (MacGregor & Smythe, 2014). The New Zealand Nurses Amendment Act 1990 provided midwives in NZ with the legal ability to practise as autonomous health professionals (Gilkison et al., 2015). The Public Health & Disability Act 2000, specifically Section 88 Service Specification of the Primary Maternity Services Notice, is the central legislation for primary maternity care in NZ (MOH, 2007). The purpose of this legislation includes the delivery of primary maternity services that are safe, informed by evidence and based on the partnership between woman and midwife, information and women's choices. The legislation is

based on the premise that pregnancy and childbirth are normal stages in the lives of most women. It supports that continuity of care, and the appropriate additional care should be provided when required by women (MOH, 2007). The legislation defines the primary maternity services, terms and conditions for payment of service providers, referral guidelines and access agreements which permit primary care providers to provide care in maternity units of hospitals. In this legislation continuity of care is emphasised as a fundamental principle of the NZ maternity system. It exemplifies the importance of partnership in present-day maternity care (Grigg & Tracy, 2013). The concept of partnership between midwife and woman strengthens this model of practice (MacGregor & Smythe, 2014).

This partnership is described by Guilliland and Pairman (1995, p. 7) as “a relationship of sharing between the woman and the midwife, involving trust, shared control and responsibility”. The pregnant woman and her chosen LMC midwife require time and opportunity to build a trusting relationship. During the antenatal period, the woman has the opportunity to develop a trusting relationship with the LMC midwife who will play an essential role in one of the most cherished times in her life. Continuity of care is fundamental to allow the woman and her LMC midwife to build on their partnership. Continuity of care provides the midwife with an opportunity to have access to the pregnant woman’s entire pregnancy journey, amplifying her confidence, experience and expertise as she observes the consequences of decisions made (Guilliland & Pairman, 1995). Continuity of care is to be provided for each woman for the entire duration of her maternity journey, regardless of her chosen place to birth, risk status or level of care she requires (Guilliland & Pairman, 1995). LMC midwives must negotiate a plan of care in partnership with woman which gives choices (Davis & Walker, 2010; Grigg & Tracy, 2013). As this partnership develops, a woman’s increased trust in her LMC midwife is expected to enhance the woman’s ability to make informed choices about her labour and birth (Guilliland & Pairman, 1998). The woman will usually discuss her decisions and options regarding her labour and delivery with her LMC midwife (NZCOM, 2008).

The LMC midwife carries the responsibility of assessing, planning and delivering maternity care to each of her women. This responsibility commences when the woman enrolls with the midwife as her lead primary care maternity provider and continues until six weeks postpartum (Grigg & Tracy, 2013). LMC midwives attend childbirth either in women’s homes or in primary birthing centres, secondary and tertiary maternity hospitals (Davis & Walker, 2010) as discussed with the woman. LMC midwives provide all the childbearing care women require and work with other health professionals to coordinate the woman’s care. The advice and expertise of obstetricians and paediatricians may be accessed. This action ensures the woman and her infant receives care appropriate to her needs (MOH, 2007). The LMC midwife exercises a great deal of influence over the experience of the childbearing woman (Davis & Walker, 2010).

## 1.5 The New Zealand LMC Midwife

New Zealand has a midwifery-led, primary maternity service where pregnant women choose their own LMC midwives (Hunter et al., 2016). LMC midwives are self-employed practitioners who are contracted by the Ministry of Health (MOH, 2007). LMC midwives care for 93.4% of women, with the remainder choosing a general medical practitioner (0.5%) or an obstetrician (6.0%) (MOH, 2015). LMC midwives practise on their own or in a group practice and provide midwifery care for women in their community. They have legal access to local maternity facilities and consult and collaborate with professional colleagues if complications develop. LMC midwives provide continuity of midwifery care through pregnancy, labour and birth and up to six weeks postpartum. An increased rate of maternal satisfaction occurs in a midwifery-led continuity care model (Sandall, Soltani, Gates, Shennan, & Devane, 2013). Most (90%) New Zealand women who give birth are satisfied or very satisfied with their LMC midwifery care (MOH, 2015).

Midwifery-led, continuity of care models has essential benefits for childbearing women. These benefits include higher rates of spontaneous vaginal birth with less intrapartum intervention. The midwife's intimate connection with the woman makes her the guardian of one of the most significant events in the woman's life, as she is both friend and expert in her relationship with the pregnant woman (Pairman, 1998).

Trust and respect are the key factors in the relationship that develops between the woman and the midwife within the midwifery partnership model of care (Guilliland & Pairman, 2010). The midwifery model of partnership is reciprocal in that both the woman and the midwife can benefit from the relationship (Olafsdottir, 2006). This relationship enables both parties to get to know each other and develop mutual respect. Respect and trust in each other will allow them to have confidence in shared processes and decision making. If the woman loses faith in the care of the LMC midwife, she can break the contract that exists between them by changing to another LMC midwife (MacGregor & Smythe, 2014). Section 88 Service Specification of the Primary Maternity Service Notice (MOH, 2007) stipulates that pregnant women have a choice to seek maternity care from another LMC midwife. As the incidence of severe perineal trauma is rising globally (Albers et al., 2005), such trauma has the potential to negatively affect this trusting relationship that exists between the midwife and women in her care.

An essential factor of being a midwife is to avoid causing harm by providing care that is evidenced-based and to be skilled in practical procedures. Evidenced-based practice will ensure women receive the best possible care during pregnancy, labour and birth (Page, 2000). The essence of midwifery is the assistance of women around the time of childbirth. Support is provided in a manner recognising that physical, emotional and spiritual aspects of pregnancy and childbirth are equally important. Midwives provide



competent and safe physical care without sacrificing these aspects (Page, 2000). The midwife's intimate connection with the woman makes her the guardian of one of life's most meaningful events as she is both friend and expert in her relationship with the woman (Page, 2000). The midwife is therefore affected when the woman in her care sustains SPT during childbirth (Edqvist, Lindgen & Lundgren, 2014). The literature search found no evidence of any research done on this topic been in New Zealand.

## 1.6 The impact of SPT on the LMC midwife

Midwives are not immune to the effect of severe perineal trauma injuries sustained by women during childbirth (Dahlen & Caplice, 2014). Midwives have feelings of being excessively responsible for outcomes, and this may impact their practice. Strong feelings of guilt for being accountable for perineal trauma and not being able to prevent the injury may surface (Cox & Smythe, 2011).

Midwives have feelings of guilt and failure when they realise the extent of perineal tears and the need for surgery because they have not been able to maintain normality. They have been found to feel guilty for delaying the bonding process between mother and child, such as when a mother has to be separated from the infant and her partner for surgery to repair the trauma (Lindburg, Mella & Johansson, 2013). They also have feelings of guilt for causing the woman physical pain. Midwives believe not being able to foresee or prevent perineal trauma as a betrayal of the trust of the parents (Lindburg et al., 2013). They have expressed feeling they did not live up to their own expectations nor the expectation of the woman, the family or her midwifery colleagues. When a woman experiences severe perineal trauma, the midwife believes this to be a sign of lacking professional wisdom (Lindburg et al., 2013). This may increase her feelings of shame and guilt.

LMC midwives express the importance of working through these feelings of shame, guilt and failure as this will enable them to move on (Lindberg et al., 2013). Processing these feelings may be achieved by engaging in conversations with the woman and her partner in the days following the traumatic birth event. These conversations involve providing the couple with an opportunity to express their feelings and answering all their questions truthfully. The LMC midwife has a chance to give the parents her perspective on the events that occurred during labour and birth and the cause of the severe perineal tear (Lindberg et al., 2013).

## 1.7 How I became interested in this topic

As a core midwife,<sup>1</sup> I sometimes encounter LMC midwifery colleagues who report feeling guilty and disappointed when a woman in their care sustained SPT during childbirth. These midwives always expressed they wish they could have done something to prevent this injury. Some LMC midwives say an injury of this severity unanticipated. They express fear the obstetric staff and their midwifery colleagues may question their practice. The LMC midwives often express feeling anxious as they fear the woman and her family may blame them. Midwives fear women will view them as unsafe practitioners and may lose Trust in their professional ability and terminate their partnership. LMC midwives also think women may lose their confidence in them as many women have a high expectation that all will be normal during childbirth. The woman may talk to others about ongoing health problems and blame towards the LMC midwife. This event may lead to dwindling numbers of women who book with the LMC midwife for maternity care. Some LMC midwives also express women may view themselves as a failure when an unexpected outcome eventuates at birth.

At the DHB where I am employed as a core midwife, a high rate of SPT occurred during the year 2014. An audit conducted on the high incidence of SPT led to a change in policy and practise on how SPT is managed in the postnatal period.

Research has been conducted on many aspects of perineal trauma, as I will show in the literature review in Chapter two. In New Zealand, no research has been done on how SPT affects the relationship between the LMC midwife and the woman in her care in New Zealand. Therefore, I chose to address the question: What is the midwives' perception of the effects on the LMC midwife/woman relationship when the woman sustained severe perineal trauma during childbirth?

## 1.8 Aims and Objectives of this study

The aim of this study was to determine how SPT sustained by women during childbirth affect the ongoing relationship in the postnatal period between the LMC midwives and the women in their care in New Zealand. The study objectives were to:

- Determine to what extent the LMC midwife is affected on a personal and professional level when the woman in her care sustains severe perineal trauma during childbirth;
- Identify how the LMC midwife coped and how she overcame this issue; and

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<sup>1</sup> Core midwife- Hospital employed midwife.

- Determine from the LMC midwife if the trauma sustained by the woman had any effect on the relationship between her and the woman during the postnatal period.

## 1.9 Outline of chapters in this thesis

Chapter one has established the topic of interest and described why it is vital to research. A description, categorisations of and risk factors for perineal tears were described. An outline of the New Zealand model of midwifery care and the New Zealand LMC midwife was provided. Chapter two is the literature review used for the thesis. In this chapter literature on the midwife, the midwife/woman relationship and severe perineal trauma are reviewed. Chapter three describes the methodology and methods used to conduct this research. Chapter four describes the findings of this research. Chapter five features the discussion about the research findings, including the limitations of this research, implications for practice and proposes further research.

## CHAPTER TWO: LITERATURE REVIEW

### 2.0 Introduction

The focus of this research is to examine how a severe perineal trauma sustained by a woman during childbirth affects the LMC midwife's ongoing relationship in the postnatal period between the LMC midwives and the women. This literature review explores research in this area, reviewing what is known to enable the value of this study. This literature review presents insights into the woman/ midwife relationship and how this impacts on the care the woman receives from the midwife. The literature review also examines the incidence and effects of severe perineal trauma on the midwife and the woman.

### 2.1 Search strategy

The literature in this section was sourced using the following data databases; CINAHL (Cumulative Index to Nursing and Allied Health), Google Scholar, Scopus, Cochrane Database of Systematic Reviews and Medline (U.S National Library of Medicine), PubMed, Medline Pro-Quest, SAGE Knowledge and Science Direct. Keywords used for this search included midwife, midwife-woman relationship, perineal trauma, third- and fourth-degree perineal tears, genital trauma, birth trauma, trust, partnership, reciprocity. Reference lists in literature were used to obtain more information on relevant topics and led to other related research articles on the chosen topic. Having reviewed the literature, these were the common themes that surfaced. The literature review findings are presented under the following headings: The midwife, Midwife woman relationship, Trust in the woman/midwife relationship, The childbirth experiences, Outcomes for women, Risk factors for SPT, Ongoing complications of SPT, and Impact on the midwife. A broader literature review was conducted to inform the discussion.

This review of the literature is presented in categories where the different key aspects are examined. The category of "midwife" was chosen as this study examines the New Zealand midwife. By reviewing the topic, information was obtained about midwifery practice. Midwifery practice has many similarities despite being practised in different countries. The midwife–woman relationship examined many various aspects of how midwives and woman interact and how these relationships may be similar in different countries despite different models of midwifery care exist in different settings. Trust is vital in any health care relationship. For midwives, the confidence of women in their care often exists on a deeper level due to the intimate nature of midwifery care. Childbirth experience was examined to see what the literature describes regarding how women experience different aspects of the childbirth experience, as not all women have similar outcomes and experiences. Risk factors for SPT examine what the literature reports on what

contributes to these injuries and the ongoing complications women may suffer after sustaining these tears. Literature regarding the impact on the midwife examines the different research conducted in different countries to see how this injury sustained in women impact on the midwife working in different countries and under different work environments.

## 2.2 The Midwife

The New Zealand midwife recognises the International Confederation of Midwives' (2005) definition of a midwife. This definition states: "A midwife is a person who having been regularly admitted to a midwifery education programme, duly recognised in the country in which it is located, has successfully completed the prescribed course of study in midwifery and has acquired the requisite qualifications to be registered and/or legally licenced to practice midwifery" (NZCOM, 2008). To practice as a midwife in New Zealand, an annual practising certificate is required, issued by the Midwifery Council of New Zealand (NZCOM, 2008).

The midwife is acknowledged as a trustworthy, accountable professional, working in partnership with women (Pairman, 1998). Midwives provide women with the essential assistance, information, guidance and care during pregnancy, labour and the postpartum period (NZCOM, 2008). The midwife may practice in different locations. This includes the woman's home, community, hospitals or in any maternity service as chosen by each woman (NZCOM, 2008). In these various settings, the midwife continues to be accountable for services rendered to those in her care. This includes a partnership with women, respect for human dignity, and advocacy for women. This also includes cultural sensitivity and a focus on health promotion and disease prevention that views pregnancy as a normal life event. The midwife cares for the childbearing woman and her family and is professionally competent, has professional wisdom and interpersonal competence. She is capable of empowering communication and positive partnership with the woman and her family. The midwife develops herself both professionally and personally (Halldorsdottir & Karlsdottir, 2011).

## 2.3 Midwife woman relationship

In the context of childbirth, an essential factor for the pregnant woman is the relationship that exists with her LMC midwife (Hunter, 2005). The quality of this relationship is fundamental for the quality of care provided during pregnancy, childbirth and the postnatal period (Lundgren & Berg, 2007). It combines all the aspects of the midwifery service (Hunter et al., 2008). Studies show that a trusting relationship between the woman and midwife is essential for the emotional aspect related to the birth experience (Dahlberg & Aune et al., 2013). This relationship represents a comprehensive perspective that involves possibilities for

personal growth and development. A positive birth experience requires the presence of an understanding, caring midwife with good knowledge and communication skills (Dahlberg & Aune, 2013) as women's experiences and expectations of their relationship with their midwife vary (Hunter et al., 2008). For some women, knowing her midwife and establishing a connection is seen as essential. For others, it is having confidence in the skills and the ability of their chosen midwife (Hunter, 2004).

For the community based LMC midwives, relationships with women in their care are of crucial significance (Hunter et al., 2008). Midwives often experience these relationships as emotionally rewarding and a source of affirmation and support. These relationships can also be emotionally challenging (Hunter, 2004). In a midwifery partnership, trivial situations can be settled effortlessly. This unique relationship has a mutually beneficial effect, but there can be a change in the dynamics between midwife and woman (Hunter et al., 2008). Other issues may be substantial and feel overwhelming and intimidating and may have a negative influence on the well-being of the midwife on a professional and personal level (Pelvin, 2010).

When the midwife realises the partnership with a woman is not working, and mutual trust is absent, she may decide to terminate the contractual relationship with the woman (MacGregor & Smythe, 2014). If a woman mistrust care received from her midwife and is displeased with the care, she expected to receive; the woman can break the contract that exists between her and the midwife. The woman may seek the services of another midwife to provide maternity care (MOH, 2007). The midwife's management of clinical and psychosocial matters has the potential to affect the development or outcome of the relationship with the woman (Creedy et al., 2000). The woman may view this as a negative or a positive experience.

Pelvin (2010) states "the midwife takes a leadership role in establishing the partnership, sustaining it throughout the life of the partnership and negotiating its completion" (p. 305). Midwives provide care to a wide range of women and therefore require considerable skills to transform and adapt the principles of partnership to ensure an individually negotiated and feasible relationship. To be close at a personal level depends on sincere, trusting relationships where the woman is approached with a holistic perspective (Pelvin, 2010).

For the woman, the postpartum period is acknowledged as a stressful time. It is a time of physical recovery and emotional adaptation to parenthood (Vanderkruik et al., 2013). For women who sustain SPT during childbirth, a variety of health problems may ensue. These problems may have an ongoing effect on the woman's wellbeing as recovery may take longer than anticipated (Vanderkruik, 2013). During the postnatal period, the LMC midwife should become aware of the impact SPT is having on a woman's physical and emotional health. The LMC midwives continue to support women while they recover from SPT sustained

during childbirth. The physical symptoms that surface in these women may impact negatively on her quality of life and affect her relationship with the infant and her family (Vanderkruik et al., 2013).

## 2.4 Trust in the LMC/woman relationship

Trust and respect are the key factors in the reciprocal relationship that develops between the woman and the midwife within the midwifery partnership model of care (Guilliland & Pairman, 2010). “Trust is the firm belief in the reliability, truth, or ability of someone or something” (Lexico Dictionary, 2019). Midwives are obligated to facilitate the development of reciprocated trust as relationships between themselves and women are established. For trust to grow in any relationship requires mutual respect, generosity, confidence and a feeling of safety between the parties involved (MacGregor & Smythe, 2014). Mutually trusting relationship of the midwifery partnership empowers women to trust the birth process (Lundgren & Berg, 2007). Midwives achieve this trust by showing women they can be trusted (MacGregor & Smythe, 2014). Childbearing women have expressed satisfaction with the NZ model of midwifery care (Ministry of Health, 2011). The community-based LMC midwife practices as an autonomous practitioner<sup>2</sup> providing continuity of midwifery care for the woman who chooses her as lead maternity carer throughout pregnancy, labour, birth and up to six weeks of the postpartum period (McAra-Couper et al., 2014). Some midwives find this way of providing care to women to be enjoyable and satisfying (McAra-Couper et al., 2014) and value the relationships they develop with the women in their care (Skinner, 2011). The woman/midwife relationship is the most vital element of continuity of care, and the value of this relationship is enriched by the woman seeing the same primary midwife or her back-up colleague both ante-natally and during labour and birth (McLaghlan et al., 2016) and in the postnatal period. The midwife acknowledges that she is not indispensable to a woman as the woman can terminate the partnership at any time by changing to a different LMC (McAra-Couper et al., 2014).

The midwife/woman relationship is one of equality and reciprocity, where both partners contribute and participate. Power is shared, and the woman is in control of the experience, which enables her to feel deep satisfaction and confidence in her abilities (Pairman, 1998). This relationship gives time for them to get to know each other and to develop their partnership. Mutual trust will enhance informed decision making and increase the woman's ability to be in control of her experience. Seeing the outcomes of decisions made increases the midwife's confidence and knowledgebase (Pairman, 1998). The midwife's focus is on the woman. Although the midwife has access to the woman's family/whanau, it is the woman who identifies the roles these others will play (Pairman, 1998). Within the midwifery partnership, certain principles must

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<sup>2</sup> Autonomous practitioner -providing care under own professional responsibility.

be adhered to if a successful collaboration is to be established and maintained. These include individual negotiation, equality, shared responsibility, empowerment, informed choice and consent (Pairman, 1998).

## 2.5 The childbirth experience following SPT

Satisfaction with the birth experience appears to be a result of women's perceptions of the interactions with their care providers (Priddis et al., 2014). Women described feelings of being abandoned due to the lack of information and education they received concerning their perineal trauma sustained during childbirth (Bick, 2004). For women and their families, birth is generally viewed as a positive, life-changing event. This time may be one of the critical psychological adjustment for women (National Institute for Health and Clinical Excellence [NICE], 2007).

For women having their first baby, unexpected experiences begin when the outcome of their birth is not as imagined (Way, 2012). It can have severe consequences not only for the woman but may also impact on the relationship with her partner and has the potential to result in a dysfunctional mother/ infant bond (Nystedt & Hildingsson, 2018). Women reported men often provide them with physical support, such as caring for the newborn but lacked emotional support for these women (Priddis, 2015). For women, the divide between the expectations and reality of the birth experience in the immediate postpartum period, and how this reality influences their ability to mother the newborn baby and the sexual relationship with the partner, has been described as a fractured fairy tale (Priddis, 2015). Communication problems can occur between the woman and her partner. Women often feel there is a lack of support from their partners about what they are going through. This has the potential to lead to isolation from the partner (Williams et al., 2005). Emotional problems caused by feelings of misunderstanding, anger, guilt and confusion may surface. The memories of childbirth may cause these feelings. These feelings may lead to anxiety, disappointment and a reluctance to contemplate future pregnancies (Williams et al., 2005). An unwillingness to consider future pregnancies can also be attributed to the fear of a repeat of perineal tear and ongoing consequences related to the SPT (Williams et al., 2015). Perineal pain caused by SPT may aggravate these feelings.

Although giving birth is often regarded as being the most beautiful and exceptional experience in a woman's life, this event can be a traumatic experience underlined by the fact that this is the most painful event that she is likely to undergo (Spaich et al., 2013). The effects of this pain and discomfort can be distressing for the new mother when she is trying to cope with hormonal changes and the demands of her baby (MaCarthur & MaCarthur, 2004). In the early days following vaginal birth, all women will experience some measure of postpartum perineal pain. Women described the level of pain experienced as unexpected and were uncertain as to whether the degree of perineal pain experienced was normal following a vaginal birth



(Priddis et al., 2012). Dissatisfaction with relieving perineal pain is explored by Salmon (1999), who identified that women's accounts are not valued as a reliable source knowledge by healthcare professionals. If midwives view perineal pain as a normal consequence of childbirth, they may minimise the impact it could have on the ability of women to carry out daily living activities and not offer enough pain relief for women to feel comfortable (Way, 2012). The women's experiences of childbirth may be negatively influenced by her unmet expectations, pain relief care and support received during labour and birth (Lundgren & Berg, 2007).

Women may have different views from midwives and other health professionals about what is normal (Way, 2012). During labour and childbirth, an event perceived as standard for the midwife may be experienced as traumatic by the woman. The woman may be ill-prepared for the childbirth experience and postnatal period (Cunen et al., 2014). Women may perceive their birthing experience as traumatic due to mode of birth and interventions that occurred during this process (Cunen et al., 2014). Women have described factors causing a negative birth experience as midwives who do not listen to their needs and the needs of their partners and displaying a lack of emotional support during the birth (Austin, Smythe & Jull, 2014). There are many situations where midwives have provided optimal care, but an unfavourable outcome occurred. The woman may perceive an adverse event as personal. She may consider the health practitioner failed to deliver the result she expected when they entered the healthcare relationship (Austin et al., 2014).

The woman's feelings and the complications suffered may impact on her psychological well-being. (Nystedt & Hildingsson, 2018). Childbirth experiences may follow women throughout life, and the overall experience is an essential outcome of labour (Lundgren & Berg, 2007). The most pivotal factor for a positive childbirth experience is the significance of the midwife's support to the woman during labour. Central to the support is the midwife–woman relationship (Ludgen & Berg, 2007). The quality of the woman's experience is an essential outcome of labour and birth and has the potential to affect future pregnancies (Lundgren & Berg, 2007). In a study conducted by Priddis et al. (2012) looking at women experiences following SPT, women reflected upon the process of perineal suturing after childbirth and how they were cared for. These women described feeling vulnerable, uncomfortable and exposed on both a physical and emotional level. Such feelings of vulnerability and discomfort appeared the potential symptoms they may develop an ongoing treatment they may receive because of perineal morbidity (Priddis et al., 2014).

Women experiencing long term urinary and faecal incontinence described the isolation and embarrassment as a contaminated and uncontrolled body. These complications impacted upon how they viewed themselves (Priddis, 2015). Women described feeling shocked at how essential bodily functions such as

passing a bowel movement and unexpected episodes of incontinence were no longer in their control (Priddis, 2015). Women described being unable to undertake basic parenting tasks in the first few weeks due to the perineal pain and symptoms associated with SPT (Priddis, 2015).

## 2.6 The woman's experience following SPT

Childbirth experiences may follow women throughout life, and the overall experience is an essential outcome of labour (Lundgren & Berg, 2007). Women and their families generally view birth as a positive, life-changing event (Priddis et al., 2012). Satisfaction with the birth experience appears to be the result of women's perceptions of the interactions with their care providers (Priddis et al., 2014).

Pregnancy-related factors, complications, women's expectations, pain relief, care, and support may influence the woman's experiences of childbirth (Lundgren & Berg, 2007). Women have described factors causing a negative birth experience as midwives who do not listen to their needs and those of her partner and displaying a lack of emotional support during birth and birth (Austin et al., 2014). There are many situations where midwives have provided optimal care, but an unfavourable outcome occurred. For some women, any adverse event may be perceived as personal. Women may consider the midwife failed to deliver the result she expected when they entered the healthcare relationship (Austin et al., 2014).

The most pivotal factor for a positive childbirth experience is the significance of the midwife's support to the woman during labour, and central to the support is the midwife–woman relationship (Ludgen & Berg, 2007). The quality of a woman's experience is an essential outcome of labour and birth and has the potential to affect future pregnancies (McLaghlan et al., 2016). Satisfaction with the birth experience appears to be a result of women's perceptions of the interactions with their midwives (Nystedt & Hildingsson, 2018).

The woman's perceptions of birth trauma may be based not only on the event but also on unmet expectations regarding the circumstances surrounding the birth (Beck, 2004) and the complications suffered after birth. For some women, the delivery may be a traumatic experience underlined by the knowledge that it is the most painful event that she is likely to undergo (Spaich et al., 2013). When an unexpected event occurs during childbirth, a woman may experience feelings of fear, confusion and having lost control (Priddis, 2015). Women have described the level of postpartum pain experienced as unexpected; and often ask whether the degree of perineal pain experienced is typical following a vaginal birth (Priddis et al., 2012).

While pain relief in labour assumes a high priority; the genuine discomfort some women experience in the first few days following the birth surprised women (Way, 2012). Midwives need to recognise and understand that perineal pain is a source of distress and discomfort, whether an actual perineal tear is present or not (Way, 2012). The impact of this pain and discomfort can be distressing for the new mother when she is trying to cope with hormonal changes and the demands of her baby (MaCarthur & MaCarthur, 2004). Dissatisfaction with relieving perineal pain is explored by Salmon (1999), who found that midwives often ignored women's accounts of suffering. Midwives view perineal pain as a normal consequence of childbirth and minimise the impact it could have on the ability of women to carry out daily living activities. The midwife may not offer sufficient pain relief for a woman to feel comfortable (Way, 2012). Midwives need to recognise that women may experience these symptoms. The midwife should provide support and information to both the woman and her family as SPT can have a significant emotional and psychological influence on the affected woman's physical and emotional wellbeing (Priddis, 2015).

Women with perineal injuries after childbirth may suffer ongoing complications such as urinary and faecal incontinence. They may avoid certain activities to reduce the chances of exposing incontinence leading to social isolation and marginalisation (Priddis et al., 2012). Women experiencing long term urinary and faecal incontinence described the isolation and embarrassment associated with SPT. Incontinence impacts how they viewed themselves (Priddis et al., 2012). In the immediate postpartum period, the expectation and reality of a woman's health problem may cause the woman confusion and emotional distress. The experience of pain and discomfort influences her ability to mother the newborn baby. The sexual relationship with the partner has also been described as a fractured fairy tale (Priddis et al., 2012). Women reported men often providing them with physical support such as caring for the newborn but lacked emotional support for them as women. Women described feeling shocked at how some essential bodily functions such as passing a bowel movement and unexpected episodes of incontinence were out of their control (Priddis et al., 2012). SPT may also alter the injured woman's understanding of her identity as a sexual being as these morbidities may influence her ability to engage in sexual activities and have an impact on her relationship with her partner (Priddis, 2015). Postnatal women have described a fear of intimacy and experiencing feelings of apprehension, anxiety and unease as vaginal and perineal pain prevented them from resuming sexual intercourse after childbirth (Priddis et al., 2012). Injury sustained at childbirth has the potential to result in a dysfunctional mother/ infant bond (Nystedt & Hildingsson, 2018).

A study conducted by Priddis et al. (2012) looked at women experiences following SPT. Women reflected upon the process of perineal suturing after childbirth and how they were cared for by health professionals. These women described feeling vulnerable, uncomfortable and exposed on both a physical and emotional level (Priddis et al., 2012). Feelings of misunderstanding, anger, guilt and confusion caused by the memories

of childbirth can lead to anxiety, disappointment and reluctance to contemplate and future pregnancies (Williams et al., 2005). Such morbidities may have a severe psychosocial impact on women and affect future birth choices. These women may also fear a repeat occurrence of perineal trauma and its ongoing complications at the next pregnancy (Williams et al., 2005). A study conducted by Way (2012) found women having their second or subsequent baby identified that previous experiences of perineal pain and trauma were meaningful in their preparation for the impending birth. The information and level of care these women require in preparation for the next delivery and postnatal period may vary. This information depends on women's prior knowledge, experience and expectations (Way, 2012).

When a woman's hope for her birth does not materialise, her unmet expectations should be addressed by her midwife (Bick, 2004). During labour and childbirth, certain events may be out of the control of both the midwife and the woman. For the woman, the disappointment of an expected outcome may be associated with the actions of her midwife (Bick, 2004). The quality of care provided by the midwife and the relationship with the woman can make a crucial difference in how the woman perceives the events (Bick, 2004). For these women, an adverse event has the potential to negatively influence the excellent relationship between them and the LMC midwife.

## 2.7 Breakdown in relationships

When behaviours and attitudes do not provide evidence for trust, the relationship between parties become unstable (MacGregor & Smythe, 2014). If the woman does not show any reciprocal behaviour of faith towards the midwife, the relationship has the potential to have undesirable outcomes for both parties (MacGregor & Smythe, 2014). The woman can break the contract that exists between her and her midwife if she distrusts the care receives (MOH, 2012). When a woman accesses maternity care from another midwife practitioner without informing her midwife, it is not an example of partnership based on open communication (Austin et al., 2014). Midwives experience this as a breach of trust from women for whom they are providing care. In these relationships, the woman disempowers the midwives, demonstrating a breakdown of equality and a violation of relational trust. The midwife recognises that she is not indispensable to the woman (McAra-Couper et al., 2014).

## 2.8 Risk factors for SPT

For the woman, her unborn child and the midwife, the second stage of labour is the most stressful part of the process of childbirth (Kopas, 2014). The literature identifies several risk factors for SPT. These are often divided into antenatal and intrapartum risk factors (Dahlen et al., 2013). Prenatal risk factors associated

with an increased incidence of SPT include primiparity, maternal age (very young and older women), ethnicity (Asian), nutritional status, previous experience of SPT, larger fetal weight, abnormal collagen synthesis, shorter perineal bodies and possibly male sex (Dahlen et al., 2013). According to Patumanond, Tawichasri and Khunpradit (2010), male infant gender is a risk factor for shoulder dystocia compared to female infants, irrespective of their birth weight. This has been attributed to male infants producing a higher level of growth hormones that increase male infant's body weight. Male infants are longer, have larger heads, wider shoulder width and chest size compared to female infants (Geary, Pringle, Rodeck, Kingdom & Hindmarsh, 2002). Intrapartum risk factors include fetal presentation and position, occipital-posterior positions, episiotomy especially midline episiotomy, instrumental birth, especially forceps delivery, the prolonged second stage of labour, the birth position adopted by the woman during the second stage of labour and an obstetric emergency such as shoulder dystocia (RCOG, 2015). Forceps delivery appears to contribute to the most significant risk of SPT, with extensions to episiotomy being a significant contributor (Dahlen et al., 2013). An episiotomy is usually performed at the stage of crowning to facilitate delivery with less risk of anterior perineal trauma. An episiotomy is a surgical cut to the woman's perineum made during the last part of the labour to assist with delivery of the infant (Necessalova, Karbanove, Jansova, Kalis, Rusavy & Pastor, 2016). It is possible to have both an episiotomy and a spontaneous tear. This may be either as an extension of the episiotomy or as a separate tear (RCOG, 2015). Spontaneous tearing may occur in primigravida women. This event is less common in multiparous women (Naidu, Tharkar & Sultan, 2016). The trends toward an increase in severe perineal trauma is not an indication of poor quality of care. This is evidence of an improvement in the quality of training as these injuries are better identified (RCOG, 2015). Women who sustain SPT during childbirth may suffer multiple complications.

## 2.9 Possible Complications of SPT

According to Webb, Sherburn and Ismail (2014) women who sustain SPT during childbirth may experience any of the following complications: Perineal pain; infection; wound dehiscence; postnatal depression; interruption to breastfeeding and interference of infant bonding; dyspareunia; altered body image, incontinence of flatus, faeces, urine; pelvic organ prolapse; and fear of repeat vaginal delivery

## 2.10 The impact of SPT on the midwife

A New Zealand study conducted by Cox and Smythe (2011) exploring why midwives leave self-employed midwifery practice describe midwives as having a feeling of being excessively responsible for outcomes. Caring for people who experienced traumatic events, pain, and suffering can create traumatic stress reactions in the healthcare professional (Rotschild, 2006). A study by Hunter (2004) explored the

importance of reciprocity between community-based midwives and women in the United Kingdom. The study found that midwives were often feeling unprepared overwhelmed and unsupported when caring for women who had an emotionally traumatic experience. The mutual relationship between midwife and woman involves the midwife's sharing in the woman's experience of childbirth. The midwife allows this experience to become part of her own life experience (Hunter, 2004). A Danish mixed-method study, examining obstetricians and midwives' experiences and existential considerations after involvement in traumatic childhood, was conducted by Schroder, Jorgensen, Lamont and Hvidt (2016). In the aftermath of traumatic childbirth, the focus is on the patient and less on the midwife. Traumatic and stressful events around childbirth situations may have a negative influence on the mental health and professional and personal identity of the midwife (Schroder et al., 2016). This research identified three major themes. Fear of being blamed by woman, peers and managers was the primary concern raised. Midwives also had feelings of guilt. This guilt was related to their opinion about the impact their action had on the course of events. Existential considerations addressed both professional and personal implication of SPT on the midwives and obstetricians. This had positive and negative influences on the participants. Positive impacts involved personal development and becoming a better practitioner by increasing their level of skills and training and thus becoming what they perceived as a better midwife or obstetrician. Negative influences included a small number of practitioners resigning from the midwifery profession, having a complete career change.

Feelings of guilt, shame and failure were identified in a study by Lindburg et al. (2013). Midwives experienced these feelings towards the woman, her partner and her colleagues. They expressed strong feelings of guilt at being responsible for the sphincter tear and for not being able to prevent it. The researchers found that midwives expressed remorse at separating a mother from the newborn child and her partner when the mother needed surgery. Also, midwives expressed feelings of guilt for causing the woman physical pain or causing future health problems such as incontinence of urine and faeces. The midwives believed that not being able to foresee or prevent sphincter tears was a betrayal of the trust of the parents (Lindburg et al., 2013). Midwives described feeling shameful and unprofessional when telling colleagues about the sphincter tear. Working through their feeling's midwives expressed that it was essential to work through their feelings of shame, guilt, and failure (Lindburg et al., 2013). A study involving midwives in New Zealand and Australia was conducted by Dahlen and Caplice (2014) to determine what midwives feared the most. Midwives described being the cause of a negative birth experience as one of their fears. Missing something that may cause harm and losing passion and confidence around normal birth was described as one of the most significant factors that cause midwives to feel fear.

The midwife's ability to correctly identify and diagnose the degree of perineal trauma is important (Jaiyesimi, 2007). Failure to recognise SPT is a cause for concern. This failure may be due to the inexperience of the midwife. Midwives should seek a second opinion if they have any uncertainty about the extent of a perineal injury (Jaiyesimi, 2007). Delayed repair of the trauma may lead to additional blood loss and an increase in the swelling of the affected tissues.

## 2.11 Summary

The New Zealand LMC midwife works in partnership with the woman in her care. This partnership built on trust, respect and reciprocity is vital for the support the woman will receive from her midwife. The childbirth experience may follow the woman throughout her life, and unexpected events like SPT can cause women to feel angry, confused and anxious. This may also influence her relationship with infant and partner during the postnatal period. If dissatisfied with the care received from her LMC midwife, the woman may terminate this relationship and seek the care of another midwife to be her lead maternity care provider. The woman's satisfaction with her birth experience is often the result of her perception of the care and support received from her midwife during labour. Midwives are not immune to the effects of SPT on the women in their care and feelings of guilt, shame and failure. Traumatic and stressful events around childbirth situations can have a negative influence on the mental health and professional and personal identity of the midwife. Events viewed by the midwife as unfavourable have the potential to potentially affect their ability to perform their usual practice. This may lead to traumatic stress reactions in the midwife.

In this literature review, I found no articles of any research conducted on the feelings of midwives when the women in their care sustained severe perineal trauma in New Zealand. My literature search found one study (Edqvist et al., 2014) conducted in Sweden examining midwives' lived experiences of a birth where the women suffer an obstetric anal sphincter injury. There is a noticeable lack of research into how the midwife is affected when women in their care sustain severe perineal trauma. In New Zealand, most maternity care is provided by LMC midwives. Research could be conducted on how New Zealand midwives are psychologically affected, the effect on their professional practice and who they turn to for support after the woman in their care sustains SPT. A qualitative research approach could be used to identify the perspective of the participants.

LMC midwives practice in a variety of settings. They have an ongoing relationship with the woman starting during the antenatal period, during labour and birth until six weeks after the birth of the infant. This partnership is built on mutual trust, respect and reciprocity. These factors are vital for the relationship. The

midwife/woman partnership is essential for both parties as it is crucial to the care and support the woman will receive during her pregnancy journey. The LMC midwife will support women during their labour and childbirth. The woman's satisfaction with labour and birth is a result of the women's perception of the support she receives from her midwife many studies have found. The relationship can be terminated by the woman if dissatisfied with care received from LMC. The LMC can end this relationship during the antenatal period if she feels the professional unsafe and not trusted by the woman. During childbirth, the woman may suffer varying degrees of trauma to the perineum. The LMC midwife is not immune to the effects of this trauma. Feelings of guilt and self-blame are identified in studies where the effects of birth trauma on the midwife were examined. Studies have been conducted internationally on this topic. No study in New Zealand has examined this phenomenon.

Chapter three will describe research methods and methodology used for this study



## CHAPTER THREE: METHODOLOGY AND METHODS

### 3.0 Introduction

When a complex phenomenon such as the relationship must be understood, qualitative methods are the primary research method of choice (Lundgren & Berg, 2007). The qualitative descriptive exploratory methodology used for this study. Qualitative descriptive exploratory research is used to obtain conventional and truthful answers to questions that are of significance to health practitioners and policymakers (Sandelowski, 2000). Data collection in qualitative studies endeavours to ascertain “the who, what and where of events” or encounters (Sandelowski, 2000, p.339).

According to Colorafi and Evans (2016), this is an excellent method of choice for healthcare practitioners as it provides rich descriptive information from the participants' perspective. A comprehensive summary of events is presented in a language comparable to that of the participants (Neergaard, Olesen, Andersen & Sondergaard, 2016). These enquiries are based on the direct descriptions from participants who have experienced the phenomenon under investigation (Elliot & Timulak, 2005). The research findings are presented in the clear-cut language that plainly described the experience under investigation (Colorafi & Evans, 2016). In this chapter, I will discuss the research methodology used for this study, participant exclusion and inclusion criteria, data analysis employed during this study.

### 3.1 Methodology

Qualitative research is a strategy that usually emphasises words rather than quantification in the collection of analysis and data (Brinkman & Kvale, 2015). Qualitative research is an umbrella term for an array of attitudes towards a strategy for conducting an inquiry aimed at discovering how people understand, experience, interpret and produce the social world (Sandelowski, 2010). In qualitative research studies, the phenomenon being investigated is explored in a more humanistic approach (Schneider et al., 2003). Qualitative research involves a close relationship between the research participant and the researcher. The participants are those possessing knowledge researchers require to obtain as they are part of the experience the researcher is examining (Schneider et al., 2003). Conducted without control or variable qualitative research allows the phenomenon to be viewed as if it would be if it were not being studied (Sandelowski, 2010). In making sense of the relationships between people, qualitative research provides insight into this experience, thereby generating an understanding, meaning and potential theory (Vaismorandi, Turunen & Bondas, 2013). Qualitative research aims to provide an understanding of experiences by those closest to the phenomenon being investigated. This is performed through examining

their perceptions, values, beliefs and interpretations (Qualitative research is the preferred option when health researchers want to share individual stories of participants, where writing is flexible, in a literary style and develop theories (Schneider et al., 2003)). When describing relationships, qualitative research can provide a rich insight into this experience and generate understanding, meaning and theory (Vaismorandi et al., 2013). Qualitative research is a strategy that usually emphasises words rather than quantification in the collection of analysis and data (Schneider et al., 2003). Qualitative researchers aim to discover how human beings understand and experience, interpret and produce the social world (Sandelowski, 2000). When a complex phenomenon such as the relationship in human life is to be understood, qualitative methods are the primary research method of choice (Lundgren & Berg, 2007). Data collection in qualitative studies endeavours to ascertain “the who, what and where of events” or encounters (Sandelowski, 2000, p.339). Qualitative descriptive exploratory research can be used to obtain conventional and truthful answers to questions that are of significance to health practitioners and policymakers (Sandelowski, 2000).

A qualitative exploratory lens is used for this study. Exploratory studies are undertaken when a relatively underexplored topic is being investigated to explore the nature of the phenomenon and other factors relating to it (Leavy, 2017). Additional aspects regarding perineal tears have been researched in New Zealand. However, little is known about the relationship between the LMC midwife and the woman in the aftermath of SPT. Exploratory research can assist in filling the gaps that exist in the knowledge of the under-researched topic. It allows the matter to be investigated from a different approach, thereby generating new insights (Leavy, 2017). Exploratory research creates an opportunity for further study as the investigation is not used for providing conclusive evidence. This type of research assists the researcher in understanding the phenomenon under examination. It lays the groundwork that may lead to further studies on this topic (Leavy, 2017).

In contrast, explanatory research identifies the data that is the only solution to a research question (Dudovskiy, 2018). Exploratory research aid in filling gaps that exist in the knowledge of the under-researched topic (Leavy, 2017). Exploratory research allows the phenomenon to be investigated from a different approach, thereby generating new insights. This initial research may indicate the researcher or other researchers towards specific research questions, methods for the data collection, participants and participants (Leavy, 2017).

## 3.2 Research design

### 3.2.1 Qualitative research

In qualitative research studies, the phenomenon being investigated is explored in a more humanistic approach (Schneider et al., 2003). Qualitative research involves a close relationship between the research participant and the researcher. The participants are those possessing knowledge researchers need to obtain as they are part of the experience the researcher is examining. Qualitative research explores the experience as revealed in and through the research participants (Schneider et al., 2003). Qualitative research aims to provide an understanding of experiences by those closest to the phenomenon being investigated. This is done through examining the research participant's perceptions, values, beliefs and interpretations (Schneider et al., 2003). Qualitative research is the preferred option when health researchers want to share individual stories of participants, write in a flexible, literary style and develop theories (Creswell, 2013). When describing something about relationships, qualitative research can provide a rich insight into this experience and generate understanding, meaning and theory (Vaismorandi et al., 2013).

Qualitative descriptive research follows the tradition of qualitative research as it is an experimental method of investigation aiming to describe the research participant's insight of an experience of a phenomenon (Neergaards, Olesen, Andersen & Sondergaard (2009). It is well suited for the why, how and what questions about human behaviour and views (Neergaard et al., 2009). With its mainly inductive approach, qualitative research is suitable for problem identification, hypothesis generation and concept development (Sullivan-Bolyai, Bova & Harper, 2005). Qualitative research is found in existing knowledge, thoughtful linkages to the work of others in the field and clinical experience of the researched group (Neergaard et al., 2009). When a relatively underexplored topic is being investigated, exploratory research is a way of learning about the subject (Leavy, 2017

### 3.2.2 Qualitative description

A qualitative descriptive method was chosen for this study to determine to what extent the midwife in New Zealand is affected on both personal and professional level after women sustain severe perineal trauma during childbirth. This method provides flexibility for data collection and data analytical methods (Sandelowski, 2010). Qualitative description is suitable to health environments as it allows for factual responses to questions about how people feel about a phenomenon (Colorafi & Evans, 2016). It is described as a method providing a "comprehensive summary of an event in the everyday terms of those events" (Sandelowski, 2000. p. 336). The use of another lens of an associated interpretive theory or conceptual framework may be used to guide these studies (Sandelowski, 2010). These theories or conceptual

frameworks serve as conceptual hooks to attach the study procedures, analysis and representation (Colorafi & Evans, 2016). For this study, the exploratory framework will be used for data presentation. Qualitative description is grounded in the principles of naturalistic inquiry. Naturalistic inquiry deals with the concept of truth, whereby truth is a systematic set of beliefs (Colorafi & Evans, 2016). The literature search revealed other studies conducted to examine aspects relating to midwives and severe perineal trauma where other research methods were utilised. Qualitative descriptive research aims to “describe a social phenomenon in detail and allow insight into the nature of a particular issue” (Tolich & Davidson, 2011, p. 9).

### 3.3 The setting

Maternity care facilities, either primary, secondary, tertiary in the lower North Island of New Zealand.

#### 3.3.1 The participants

Community-based LMC midwives, who conducted a birth where the woman sustained severe genital tract trauma in the last twenty-four months, were invited to participate in this study. The participants were required to have an access agreement with maternity units in the geographical area where they practice. LMC midwives who conduct home births were included in the invitation to participate. The LMC midwife had to have a caseload of a minimum of four women per month and had to have been in practice for more than two years. A minimum caseload of four women per month will ensure the community-based midwife has adequate experience in labour and birth practice. Midwives with two or more years of practice experience will exclude new graduate midwives who have little labour and birth experience as a community-based midwife.

#### 3.3.2 Recruitment

Sampling consisted of eight participants, purposefully selected for this study. The participants were recruited from three geographical locations over lower North Island of New Zealand. To recruit the participants; information pamphlets were distributed (See appendix 3). Qualitative inquiries generally emphasise in-depth interviews on a comparatively small number of research participants who are purposefully and strategically selected (Carpenter & Sutto, 2008). Purposive sampling refers to the intentional selection of participants who can provide essential information that cannot be obtained through other channels (Carpenter & Sutto, 2008). Purposive sampling functions on the belief that best information is collected through emphases on a relatively small number of participants (Denscombe, 2010) deliberately

selected based on the crucial information they can provide. Instead of empirical generalisation, these participants offer an in-depth understanding and insight into the findings (Liamputtong, 2010).

### 3.3.3 Participant Criteria

Inclusion criteria were community-based midwives who had a caseload of four or more women per month; had practice experience greater than two years; and who had cared for a woman with severe perineal trauma in the previous 24 months. Exclusion criteria were community-based midwives who had a caseload of fewer than four women per month; had practised for less than four years; and who had cared for a woman with severe perineal tract trauma during the previous 24 months.

## 3.4 Data Collection

According to Braun and Clarke (2013) one on one, face to face, semi-structured interviews are the dominant form of qualitative interviews. This type of interviews are best suited to answer research questions examining participant experiences. As these participants have personal involvement in the phenomenon being investigated, they can provide rich and detailed answers to the interview questions (Braun & Clark, 2013). This data collection method allows for comprehensive and often unexpected accounts from the participant's perspective on the topic (O'Leary, 2014).

Semi-structured interviews allow for advance preparation of a topic guide with a list of questions or areas to cover with each participant (Polit & Beck, 2004). This interview method steers the interview and allows participants to provide more details in their own words. This method allows for a natural flow of the conversation (O'Learey, 2014). It offers an opportunity to ascertain if questions are clearly understood by the participants (Walliman, 2001). The participants can be encouraged to elaborate their answers, making use of valuable tools such as visual signs such as smiles and nods to promote complete their answers (Walliman, 2001).

A pilot interview was conducted with a midwifery colleague. I transcribed the pilot interview verbatim. This pilot interview enabled me to practice and become familiar with the interview process and verbatim transcribing. The data obtained from this interview is not included anywhere in this study.

### 3.4.2 Interviews

Semi-structured questions were used to conduct the interviews. Semi-structured interviews allow for advance preparation of a topic guide with a list of questions or areas to cover with each participant (Polit

& Beck, 2004). An interview guide is a series of questions that guide the conversation with the participant (O'Leary, 2014). An interview guide assists in build rapport with the participants, making them feel comfortable, helping participants in disclosing personal information (O'Leary, 2014). This interview guide steers the interview and allows participants to provide more details in their own words and allow for a natural flow of the conversation (O' Leary, 2014).

These interview questions were not rigidly adhered to in terms of the precise wording of questions, or the specific order the questions were asked (Braun & Clarke, 2013). Not asking questions in the direct order as per the interview guide allows the researcher to be flexible (Braun & Clarke, 2013). Spontaneous and unanticipated questions were asked to enable the participants to discuss issues that are important to them (Braun & Clarke, 2013). Open-ended questions encourage the participants to provide in-depth and detailed responses and to discuss what is important to them. This process allowed me to capture their responses in their own words (Braun & Clarke, 2013). During interviews, notes were made by me indicting nonverbal responses, including laughter, facial expressions, pauses emotional expressions made by participants.

An audio recording device (Sony TCM-150 cassette recorder) was used for the audio recording of each interview. Before the start of each interview, participant permission was obtained to audio record the conversation. The recorded interviews were fully transcribed verbatim. Data were analysed by me. Confidentiality of each participant is maintained by assigning a pseudonym to each participant (Polit & Beck, 2004). Each participant was requested to choose her alias. This process enabled the participant to feel comfortable when addressed by her chosen name during the interview.

Eight participants were interviewed for this study. Ethical approval initially obtained to interview five or six participants. At a later stage, ethical approval was obtained to include more participants, as eight participants responded to the invitation to participate in this study. Factors considered when decisions made regarding sample size include the scope of the research and the amount of useful information obtained from each participant (Carpenter & Sutto, 2008). As more aspects of the phenomenon emerged, more participants were interviewed. The additional interviews ensured enough data was obtained to account for additional information that arose regarding the phenomenon.

### 3.4.3 Interview questions

A prompt question such as “tell me about your experience of caring for a woman who sustained severe perineal trauma “were used. Prompt questions were asked to encourage participants to elaborate. The literature search in chapter two had similar themes for my objectives. I developed questions to gain

information from the participants. I attempted to gain a better understanding of their experiences of the phenomenon during different stages of the woman's pregnancy.

The interview guide consisted of the following topics.

- Tell me about your relationship with the woman during the antenatal period
- Explain to me what she was like, as in her personality
- Tell me how you supported her
- Tell me about her labour and birth
- Tell me about the circumstances that made you think she had a perineal tear
- Tell me about her behaviour when you told her she had a tear
- When you saw her again after the birth what did you two talk about
- Tell me about her postnatal period
- Tell me about your feelings when the tear was diagnosed
- Explain to me your relationship with her during the postnatal period

### 3.5 Data analysis

As a flexible and useful research tool, the thematic analysis provides a rich and comprehensive account of the data (Braun & Clarke, 2006). It involves the search for and the identification of common threads that extend across an entire interview or set of transcripts (DeSantis & Noel Ugarriza 2000). The thematic analysis provides a purely qualitative, detailed, and nuanced account of data (Braun & Clarke, 2006).

Another characteristic of data analysis in the thematic analysis is drawing a thematic map. This map refers to the visual presentation of themes, codes, and their relationships. It involves a detailed account and description of each theme, their criteria, exemplars and counterexamples, and other similar details (Vaismorandi et al., 2013). As one part of data analysis, it helps with reviewing themes and achieving the aim of identifying coherent but distinctive themes (Braun & Clarke, 2006).

During the pre-analysis phase, initial reading of transcribed interviews provided insight and understanding of the content and memo writing, noting down relevant words and phrases that started to enfold (Elliot & Timulak, 2005). Repeated readings of transcripts helped identify repetitions and other insignificant phrases or words that deviated from the topic. These issues were later reviewed with my research supervisor to ensure the data that consist are relevant aspects and are not ignored (Elliot & Timulak, 2005). The data was analysed using thematic analysis process as described by Braun & Clark (2006).

### 3.5.1 The six steps of data analysis

#### i. Transcription

Verbatim transcribing of recorded interviews is the first step in preparing data for the analysis process (Elliot & Timulak, 2005). The participant's spoken words were preserved in the sequence spoken (Sandelowski, 1995). Included were the nonverbal responses such as facial expressions, laughing and sighing made by participants during interviews. Proofreading of transcripts against audio recorded interviews provided me with the opportunity to identify key phrases that may stand out in interviews (Sandelowski, 1995). The researcher did verbatim transcribing of all audio-recorded data.

#### ii. Reading and becoming familiar with data

Being immersed in the data signals the first steps of analysis of qualitative data and allowed familiarity with the dataset (Braun & Clarke, 2013). Reading and re-reading of data set allowed for noting down initial ideas while searching for patterns and information relating to the research questions. Taking note of prominent and significant phrases that were being spoken or repeated by research participants were highlighted in my transcripts. Re-reading data and listening to recordings several times provided a sense of whole data content (Sandelowski, 1995) and gave a broad understanding of the data (Braun & Clarke, 2006).

#### iii. Generating initial codes

During reading and re-reading the dataset, initial codes were generated by identifying specific features in the entire data set that appears exciting and significant. This process was performed using different colour paper and assigning each perceived code to a colour paper. Arranging and organising data relevant to each code happened with data from each data set and distinguishing between verbally expressed meaning and underlying meanings (Flick, 2014).

#### iv. Searching for themes

Developing themes from coded data was achieved by examining codes and coded data and generating potential patterns. All the codes were arranged into possible or interim themes. All the data relevant to each of these potential themes were sorted. References were made to the relationship between codes, themes and subthemes that emerge (Flick, 2014).

#### v. Reviewing each theme

Themes identified were reviewed to check which themes to be combined, separated or discarded. Checks were performed to determine if the themes work concerning the coded extracts and the whole data set (Flick, 2014). It is essential to identify the themes with a central concept that capture the most significant patterns in the data pertinent to answering the research question (Braun & Clarke, 2013). Some themes were provisional as they were revised and refined through the ongoing analysis process. Discussion and consultation with the research supervisor led to clarification regarding the processing of relevant themes.



Breaking down themes into sub-themes and leaving out less significant themes were done to redefine the developing codes (Flick, 2014). Subthemes capture and develop notable specific aspects of the central organising concept of one theme (Braun & Clarke, 2013). The use of a visual thematic map was a useful tool and assisted in examining the relationships between codes and themes and subthemes.

#### vi. Defining and naming of the themes

This step in the analysis process was performed to ascertain if the potential or provisional themes suited well with coded data, and the data set collected during interviews. Reading and re-reading the coded and collected data to ensure the provisional theme function well in comparison to this data. The themes had to capture the significance of the data and answer the research question. Reading the transcribed, un-coded data was done, ensuring identified themes captured the meaning of the dataset about the research question (Braun & Clarke, 2013). This process facilitated the identification of each theme and what they reflect (Flick, 2014). A clear, well-defined definition and named was assigned to each emerging theme. Each theme contains a distinct emphasis and rationale and collectively provide a robust, logical and significant depiction of the dominant patterns from the data that focus on the research question. The selection of citations and quotes from the coded data was made to illustrate the different components of each theme. A narrative truthful to the data needed to emerge from these themes (Braun & Clarke, 2006).

#### vii. Writing the report

Writing the report is the final step in the analysis process. The analysis of the data is written in the report. This process is performed in a manner that can be interpreted and understood by readers of the report. The report contains examples of distinct and credible extracts from data that relate to identified themes identified, research question and the relevant literature on the subject.

**Table 2. Example of data analysis**

Piece of Dialogue	Code for each piece	Code grouping	Emergent Theme
<p>I don't want to get bad feedback at the end</p> <p>That feedback think is a bit of a stink</p> <p>I checked for feedback; there was no bad feedback that could be traced to this woman or my practice.</p> <p>If you get bad feedback, you remember, and</p>	Bad feedback on practice	Feedback	Midwives fear of negative feedback

round that time I haven't got any negative feedback			
-----------------------------------------------------	--	--	--

### 3.6 Rigour and validity

During the interview process, validity was addressed by ensuring the content of the research question focussed on the research objectives. To ensure the interviews are carried out to a high standard, interview techniques building rapport and trust were used. This was done to make the participant feel comfortable (Gray, 2009). This process included informing the participants how the interview was going to be conducted and obtaining each participants permission to audio record the conversation. Each participant was reminded audio recording could be stopped at their request. During three of the interviews, the audio recording was stopped at the request of the participants. Every effort was made to maintain participant confidentiality. Before each interview commenced, the participant was requested to ask questions from the researcher regarding the research project or to provide clarification on any issue they did not understand. Participants were prompted to expand and elaborate on initial responses. This would ensure more information and descriptions are obtained (Gray, 2009). An example of this was asking the participant what she means by rolling her eyes, or making a particular facial expression when speaking, encouraging her to express her feeling. This ensured each interview produced the data it intended to provide (Rees, 2011). I listened carefully and steered the conversation back on track during digressions (Gray, 2009).

Questions posed were clear and unambiguous, ensuring each participant interpreted every question the same. To ensure representativeness and uniqueness of the data population, participants representing those referred to in the research questions were interviewed (Parahoo, 1997). Prolonged periods of engagement with each participant assisted with the process of building a rapport with participants, increasing the likelihood of participants sharing useful and truthful information (Polit & Beck, 2004). Being a midwife, I made this easier as some participants noted feeling comfortable sharing their intimate thoughts, feelings and experiences relating to the woman in their care with me. Many participants reported being grateful for having the opportunity to share specific details with me, knowing their identity will not be revealed.

To ensure trustworthiness, all collected data were systematically analysed by myself under the guidance of the research supervisor. The research supervisor verified the analysis and interpretation of the collected data were performed correctly. To ensure transferability, I described in steps all the details taken, allowing

others to follow the process and verify research findings (Parahoo, 1997). A full explanation of the methods used is provided in this chapter. This information offers readers of the research project with the relevant details of methodological details employed to ensure the study is auditable (O`Leary, 2014). Identification of difficulties encountered in study design, data collection, and other testing analysis procedures are identified in the report.

## 3.7 Ethical implications

### 3.7.1 Consent

Obtaining voluntary informed consent is a fundamental requirement before data can be collected (Dawson & Pert, 2003). Participants must be able to understand the nature of the research project and their involvement in the research project before giving consent to participate (Denscombe, 2010). Participants should be made aware they have the choice to withdraw from the study at any time without explaining (Long & Johnson, 2007). Information and consent forms included relevant information including the name of the research institution, the title of the research project, invitation to participate, requirements for participant selection and purpose and aim of the study (Tollich & Davidson, 2011). Explanation of procedures, description of potential risks, discomforts and the potential benefits of the proposed study (Tollich & Davidson, 2011) was explained to participants before they gave written consent to participate in this study. (Appendix 1 & 2).

### 3.7.2 Right to privacy

Research with humans involves intruding into personal lives, and the identity of research participants must be kept confidential (Polit & Beck, 2004). Data collected should not be traceable back to individuals (Leedy & Omrod, 2013). Each participant was requested to choose a pseudonym that was used by myself to address them during the interview.

### 3.7.3 Hazards to the emotional wellbeing of participants

The participants were reassured the recording device would be switched off at their request. (Dawson, 2009). During the interviews, the researcher confirmed with the participant if the session was to be stopped or postponed (Long & Johnson, 2007). Emotional moments were handled with sensitivity and judgement by listening to respondents. They were not probed for more information that may lead to increase emotional discomfort. I contacted each participant via email a week after the interview was conducted. I enquired after their well-being, knowing that disclosing sensitive information may have brought up many painful and unpleasant memories. All the participants assured me they were well and thanked me for the

opportunity to tell their stories. I repeated this email a month later and got the same response from each of the participants.

### 3.7.4 Confidentiality of data

Each participant was informed of the difference between confidentiality and anonymity. Data collected will be shared in a condensed form and used as a direct quote from the interviews (Long & Johnson, 2007). Choosing of a pseudonym by each research participants and using the pseudonym during the data collection process and the final research report is a common way of ensuring personal information and data is kept confidential (Leedy & Omrod, 2013). The identity of participants is protected in the research report. Irrelevant details that may reveal their identity were omitted from this report (Leedy & Ormrod, 2013). Recorded voices are more recognisable than printed words, and the recordings are kept in a locked safe in my home office. When colleagues are used as research participants, the relationship between researcher and participants can change as colleagues may be reluctant to be truthful in their response to questions (O`Leary, 2014). The research participants were respected and thanked for the contribution they gave towards the research process. The participants appreciated the respect shown to them. The respectful approach made them feel comfortable to disclose truthful information (O`Leary, 2014). Information that may potentially reveal the identity of any of the participants are not be published (O`Leary, 2014). Additional data is stored on a password-protected computer, only available to me and my research supervisor.

### 3.7.5 Honesty

Research findings are reported honestly without misrepresenting the findings. No fictitious data are being used to support a specific conclusion, as this represents scientific fraud (Leedy Ormrod, 2013). Details of the research process are transparent (O`Leary, 2014).

## 3.8 Treaty of Waitangi considerations and obligations

The Treaty of Waitangi is the founding document of New Zealand. The principles of partnership, protection and participation implied in the Treaty should be respected and where applicable, be incorporated into all health research proposals (Hudson & Russell, 2009). My research project was discussed with representatives of Nga Maia Māori Midwifery Collective and with the Māori Health representatives at my District Health Board. This discussion was to determine the best approach to data collection and analysis in anticipation of how this research may impact on Māori participants or impact on Māori health (Hudson & Russell, 2009). Consultation ensures a good starting point to work together and maintaining a good research partnership with Māori researchers and communities (Hudson & Russell, 2009). Familiarity with the

principles of the Treaty of Waitangi, particularly partnership and its implications for Māori health is essential. Informed consent may be obtained from individuals and representatives such as whānau, hapu or iwi (HRCNZ, 2010). Endorsement and support for this study were obtained from Nga Maia O Aotearoa Māori Midwives. Unfortunately, no Māori midwives responded to the invitation to participate in this study.

### 3.9 Rigour and validity

Participants were prompted to expand and elaborate on initial responses (Arksey & Knight, 1999), enabling a more data-rich description were obtained (Gray, 2009). This ensured each interview produced the data it was intended to provide (Rees, 2011). I carefully listened to responses and steered the conversation back on track during digressions (Gray, 2009). Questions posed were clear and unambiguous to ensure each respondent interpreted every question the same (Parahoo, 1997). To ensure representativeness and uniqueness of the population from whom data are collected, participants needed to represent those referred to in the research question (Parahoo, 1997). Prolonged periods of engagement assisted with the process of building rapport with each participant, increasing the likelihood of participants sharing useful and truthful information (Polit & Beck, 2004).

All data collected were systematically analysed by the researcher under the guidance of the research supervisor, who verified that the analysis and interpretation of collected data were correctly conducted. To ensure transferability, the researcher described in detail all the steps taken during the research process. These steps will allow others to follow the research process and verify the research findings (Parahoo, 1997). A full explanation of the methods used is included. This will provide readers of the research project with relevant details of methodological details employed to ensure the study is auditable (O'Leary, 2014). Identification of difficulties encountered in study design, data collection and any other testing and analysis procedures are included in the report (Rees, 2011).

#### 3.9.2 Reflexivity/ work on this one

As a core midwife, I have first-hand knowledge of the midwifery profession. Before the interviews, I had to assure the research participants that as a midwife, I was there to listen to their experiences and not judge their actions. I informed them as LMC midwives their relationship with women in their care was on another level compared to that of the core midwife. Core midwives only care for women for a few hours a day. The LMC midwife has an ongoing relationship and partnership with each woman in her care. My role as a researcher was to gain knowledge and information from the LMC midwife on her experiences with women who sustained SPT during childbirth.

Response to the advertising for participants willing to participate in this study was initially slow. The participants were based in three different geographical areas of the lower North Island of New Zealand. I had to travel to these locations to conduct interviews. Two of these interviews were conducted on the same day. I found this to be an emotionally and physically exhausting experience. Conducting interviews take a lot of time and energy due to the intense concentration and engagement with the participants. I had a fear of missing or overlooking something significant revealed by participants. I would miss the opportunity to ask for elaboration or probing questions.

Transcribing the audio recorded interviews was time-consuming. I transcribed each interview before I interviewed the next participant. Prompt transcribing allowed me an opportunity to listen and determine where I could improve during the following interview. Transcribing interviews were time-consuming but were helpful as this assisted with becoming familiar with the data. Listening to the conversations made me feel emotional, especially when participants expressed sadness. Discussions with my research supervisor helped me with working through these feelings. I contacted each participant a few days after the interview to enquire about their wellbeing. All the participants expressed being grateful for being allowed to tell their story in a non-judgemental, confidential environment.

I experienced difficulties in deciding the most appropriate codes as underlying meanings of some aspects of data initially were not fully understood (Polit & Beck, 2004). Several readings were required, and discussion with my research supervisor assisted in grasping certain features. During one interview, a participant was always giggling when talking about the birth and trauma the woman sustained during childbirth. This giggling continued while speaking about the postnatal period. While listening to audio recording and transcribing this recording, my initial thoughts were that the participant was not taking the matters discussed seriously. I contacted the participant a few days after the interview to enquire about her wellbeing. She disclosed she felt nervous about discussing the events as this was the first time, she had an in-depth discussion about these events. The participant revealed feeling much better after being allowed to talk openly about the events. After I discussed this with my research supervisor, I concluded this participant's giggling was due to nervous laughter. Initially, some themes were not identified as problems encountered with fully understanding the significance of the content of data.

I often travelled long distances to interview the participants in different geographical locations. Transcribing of the audio recordings was commenced as soon as possible after the interview was conducted. I once conducted two interviews in one day, and I found this to be emotionally exhausting. Conducting two interviews on the same day only once as this day was the only time two of the participants in a specific geographical location was available to be interviewed.

### 3.10 Significance and relevance of this study

Midwives are considered the guardians of normal birth (Fahy & Parrat, 2006). The midwife and woman in her care have a close relationship that has been described as a friendship (Rice & Warland, 2013). When caring for women during labour and birth, midwives connect with each woman, her partner and unborn child (Thelin, Lundgren & Hermansson, 2014). Job satisfaction and motivation are essential outcomes of a strong women/ midwife relationship during pregnancy, birth and the post-natal period (Leinweber & Rowe, 2008). In the event of a traumatic birth experience, the prime focus will be on the woman (Shroder, Jorgensen, Lamont & Hvidt, 2016). The midwife, however, may receive no support as distressing, psychological episodes are often seen as a normal part of midwifery practice (Wallbank & Robertson, 2013). Exposure to trauma or emotionally painful events has the potential to negatively affect the midwife's wellbeing and the care provided to women. Midwives may have feelings of intense fear, helplessness or horror (Pezaro et al., 2016) when they conduct a birth where the woman sustain SPT.

This research is essential as no other studies conducted have examined the effect on the New Zealand LMC midwife/ woman relationship where the woman sustain severe perineal tract trauma during childbirth. The findings of this research will provide some insight into the experiences of LMC midwives who have encountered this event. It will inform discussion around how midwives may be supported in their day to day work. Midwives reported when being becoming fearful while caring for women giving birth; they were less able to care for the woman effectively. Midwives' level of anxiety and fear has the potential to negatively affect the birth outcomes for women (Kennedy & Shannon, 2004).

### 3.11 Summary

This chapter outlined the underlying theory and processes that guided the research, data collection and analysis. A discussion of the rationale for the chosen methodology and the choice for using a qualitative description is provided. Findings from the thematic analysis guided by Braun and Clarke's methods generated three themes outlined in the next chapter.

## CHAPTER FOUR: RESEARCH FINDINGS

### 4.0 Introduction

This chapter details the findings derived from the themes developed using thematic analysis, presented with supporting quotes. The first theme, building a relationship with the woman, describes how the midwife forms a partnership relationship with the women who book with them pregnancy care. It gives an insight into the importance of establishing a reciprocal relationship between the midwife and woman. The subthemes developing care plans and trust and respect illustrate the importance of the woman having faith in her midwife to care for her during her labour and birth. The second theme, participants' perception of the effect of SPT on women, describes the participants' understanding of how these women were affected at different stages during the post-natal period. The sub-themes emotionally affected and physically affected deals with issues the woman had to deal with after the trauma during the postnatal period. The third theme describes the participants' perception of SPT on themselves. Subthemes describes feelings of guilt and self-blame, loss of confidence experienced by midwives, justification given for tears, seeking support from colleagues and examining their practice and fear of receiving negative feedback from women. Unexpected findings describe the ongoing emotional impact the severe perineal trauma has on the woman during her next pregnancy and the ongoing health issues faced by some women.

### 4.1 Participants

Eight LMC midwives were interviewed for this study. Each midwife cared for a woman who severe perineal trauma in the previous 12 to 24 months. All these midwives had been practising as LMC midwives from 4 to 30 years. Five midwives were educated overseas and immigrated to New Zealand. Three of the abroad trained midwives immigrated from the United Kingdom, one from Canada and one from South Africa. All midwives identified as a female. Their ages range from 28 to 65 years. None identified as New Zealand Māori. Participants practice as LMC midwives in three different geographical regions on the lower North Island of New Zealand. The interviews ranged in the timeframe from 45 to 90 minutes, and recorded interviews were transcribed verbatim by the researcher. Pseudonyms, used to protect their identity, were chosen by the midwives themselves. Throughout this chapter, quotations from each midwife. Their chosen pseudonyms were used to protect their identity.

### 4.2 Findings

This study identified three themes. Building a relationship and forming a partnership with women was identified as the first theme. The second theme identified is the midwives' perception of SPT on women.



The personal and professional impact of SPT on midwives identifies as the third theme. The midwives acknowledge the importance of building a good relationship with each woman in her care. The relationship is essential in ensuring they form a good partnership. The quality of this partnership between the woman and midwife is vital for the support the midwife will give the woman during the woman's pregnancy journey. Although the perineal trauma sustained by women were physical, the ongoing effects for these women varied as some suffered more ongoing physical effects while others were emotionally affected. The participants were negatively affected as they reported feeling guilty, some blamed themselves and others feared being accused by women for perineal trauma sustained during childbirth. Some women may have ongoing health issues that surface after discharge from the participant's care, and the midwives only become aware of this when the woman returned to her for care with a subsequent pregnancy. Participants reported feeling trusted and appreciated by these women when this happened and attributed the woman's return to her to a good relationship built during the previous pregnancy.



Figure 1. Themes and subthemes identified in the study

#### 4.2.1 Building a relationship with women

Midwives reported they got to know the women well and worked on establishing a trusting relationship during the antenatal period. This relationship is vital to laying a foundation for a reciprocal partnership with women in their care. This relationship is formed to give good midwifery care and support to women and enhance each woman's individual experience during the pregnancy. Developing this partnership between the midwife and a childbearing woman takes time and involves communication, honesty and trust between the two parties, the midwives reported. The relationship requires reciprocity as this is the essential element for the partnership to work. The midwives gave descriptions of the relationship with women in their care during the antenatal period;

*[ We had] a very good trusting relationship, and yes mutual trusting relationship (Liz).*

*When you are case loading as a midwife, I take a small caseload and spend about 45 minutes to an hour with each woman. And then with some woman, you need a lot more time, so I got to know her pretty well (Bea).*

*I only met her at probably the beginning of the third trimester, so we had to build up a relationship quite quickly (Bea).*

Forming a good relationship with women during the antenatal period is essential for midwives as a good relationship between the two parties is vital for the support women will receive from her midwife during this journey. By getting to know each woman and assessing their needs, midwives became aware that women required different levels of care and some women needed more emotional support and encouragement than others.

*[She was a] very, very anxious lady, very anxious and nervous. The whole way through the pregnancy I reassured her, reassured her (Carol).*

*I had been very close to her; she was a previous client; we had a very good relationship (Rose).*

In contrast, midwives described women who required less emotional support and different levels of care compared to other women.

*I may be thinking, well I am going to need to speak to her about her 28-week blood test this week. I was going to talk to her about doing a fasting blood sugar, and she would like to say, I am due my blood test this week, aren't I. She would always be in front of me, and I would always feel like I was playing catch up (May).*

*She was very firm about what she wanted and what she didn't want (May).*

In a midwife/ woman relationship, the partnership is based on negotiation, equity and shared decision making. When a midwife felt ill at ease in this relationship, it put pressure on the midwife. Despite having these feelings, the midwife had a duty to continue supporting the woman and gave the woman the midwifery care she required. Ongoing support for the woman was provided even when the midwife disagreed with the woman's decision or when the woman's wishes regarding care was in conflict with the midwife's beliefs and values.

*I felt at our first meeting that I was being interviewed and I felt that set the tone for our relationship a little bit (May).*

*I would say the early visits (pause) [was] strained; it didn't flow easily, that was my perception (May).*

*[It] took a long time for her to warm up, but she did warm up eventually and um it was a bit hard to read (pause) whether she was enjoying the relationship or not. She was just a bit hard to read; she was just a bit busy with her own life and not really sort of committed to the pregnancy that much (Goldie).*

*I guess I HAD (emphasized the word) to take responsibility for it because what else could I do (May).*

*I felt she didn't respect my professional responsibility, given that she was a [health professional]. I felt like she hasn't really put herself in my position because she was asking a lot of me. (May).*

The midwife and woman worked together, creating a care plan to ensure the woman's expectations and wishes were met. Care plans may involve the place of birth and what the woman requires for pain relief and her choice regarding support during labour.

*Yep at 36 or 37 weeks, we made a birth plan together, and she wanted to have a normal birth, she wanted to come into labour by herself (Rose).*

*We made a thorough care plan about doing a controlled birth this time by inducing her so we can be present all the time even trying to do a waterbirth (Liz).*

#### 4.2.1.1 Trust and respect

The words trust and respect were mentioned by midwives when describing how women felt about the care they received. The midwives revealed women trusted them to support their decision regarding labour, mode of birth and birth location.

*Actually, her respect for me was for me being able to let her birth and doing what she wanted (Rose).*

*So, I mean the fact that the woman has come back to me as her LMC, I guess you could say you know she clearly didn't have a problem with me (Carol).*

*I felt a lot more respect from her for me as a professional because actually she recognised that I knew what I was doing cos she had obviously trusted what I was doing (Rose).*

*We had discussed when another midwife might come and that sort of things, so I think allowing her to birth how she wanted rather than me saying well you have to do this now and this now and why don't you do think about doing this and that actually her respect for me was from being able to let her birth and doing what she wanted to do (Rose).*

The development of trust involves the midwife demonstrating faith in the woman. In return, the woman will place confidence and trust in the midwife. As the two parties get to know one another, an understanding of each other develops, leading to a good midwife/ woman relationship. Devising care plans for the woman's labour and birth is a confirmation of their partnership and trust. This will ensure the woman's expectations are met, and a good outcome is assured for both the parties.

#### 4.2.2 Midwives' perceptions of the effect of severe perineal trauma on women

When the woman sustained SPT during labour, both the midwife and the woman were affected by this event. Emotions of fear for the woman clouded happiness at achieving a vaginal birth. Feelings of anxiety surfaced at the separation from her baby. Women breastfed their infants before being separated from the infants. Women were affected differently at different stages during the post-natal period. Various effects of the trauma affected and influenced women in diverse manners.

#### 4.2.2.1 Fear of being separated from the baby

Midwives described women's happiness with achieving a vaginal birth. Unfortunately, the joy was marred by sadness. Women had to be separated from their infants soon after birth when being transferred to the operating theatre for the repair of perineal trauma.

*She was happy with the baby but distraught to be going to theatre (Bea).*

*There was the separation from her baby, it was very traumatic for her and of course it is (Bea).*

*She was disappointed that she now had to go to theatre, she had to have a spinal. She had to be separated from her baby and I think that was more of her concern, that put a damper on the whole experience umm (May).*

*She was really upset that she had to let go of the baby it was an unnecessary separation to be separated. They'd be devastated because they understand the need to be with the baby (Goldie).*

Midwives reported ensuring the baby was breastfed or given colostrum before the woman transferred to the operating theatre for the repair of the perineal tear.

*They did antenatal expressing for colostrum. I am a really big fan of antenatal expressing, so she could put it aside not having to worry about her baby not getting fed and get on with the business of having the procedure done (Bea).*

*She had managed to give baby a good breastfeed before she went um, she had a small collection of colostrum which she knew we had (May).*

*Once they got her all consented, I thought I would just see if I could get the baby to Breastfeed. And the baby just latched on beautifully for the five or minutes before she went to theatre, so that was really good (Christina).*

*She had contact with baby skin to skin and enjoyed at least both side because by the time she went to theatre the baby had a feed (Liz).*

#### 4.2.2.2 Effects of SPT on women in the first few days after the birth of the infant

Midwives descriptions of women's immediate reaction after being informed of severe perineal trauma sustained varied. Midwives described some women as being happy with achieving a vaginal birth despite sustaining SPT. Women's feelings immediately after the birth of the baby could be overshadowed by the relief that labour is over and the happiness of having the baby.

*She really appreciated having a normal birth this time and that was her focus during pregnancy - it did make a difference with her that she had had a normal birth (Rose).*  
*[She was] really grateful (laughing out loud,) really grateful for her birth and for the safe birth (Bea).*  
*She was euphorically happy about the baby (Goldie).*

The midwives reported this initial reaction could be due to women not understanding the full impact of the perineal trauma sustained and the potential implications the injury may have on a future pregnancy, mode of birth or their reproductive health.

*I don't think she actually understood what happened (Goldie).*  
*[She] understood it was serious [but] wasn't kind of phased by it really,*  
*She knew she had something significant (Rose).*

In contrast, the midwives revealed other women reacted differently to being informed of the diagnosis of the trauma. This reaction was potentially due to immediate pain felt by women, or the disappointment on being notified of the need to be taken to the operating theatre for perineal repair under anaesthesia.

*She was very, very teary, sore [and] quite stunned (Bea).*

*She was devastated because this whole part of (pause) oh but I've had this beautiful normal delivery and I am in this low-risk birth unit, and everything should be fine (Goldie).*

Midwives reported for some women, satisfaction with the birth outcome was due to their birth plan being adhered. Midwives revealed women were happy with the support they received from the midwife during labour and birth.

*I kept her safe, I kept her informed, because she was able to make decisions that was right for her and that I was there for her to support her in what she wanted to do (Rose).*

*They both knew there were risks, but actually, we were still able to follow the plan they wanted to and how they wanted to birth and wanted to change their birth from previous birth experience (Rose).*

Midwives reported despite reacting differently to the diagnosis of SPT; women were happy to have their baby

#### 4.2.2.3 The effects of SPT on women during the six weeks while under the care of the LMC midwife

The midwives revealed during the six weeks postpartum, while women were still under midwifery care, a variety of issues surfaced. Some midwives described women who suffered no complications and healed well.

*It was fine. It was actually really good; there were no complications (Liz).*

*Even though she had a fourth-degree tear she recovered well and faster than she would have if she had a caesarean section (Rose).*

Midwives gave descriptions of women who experienced problems involving the care of the baby.

*It was not easy to care for the baby as she was having sore boobs and a sore tail end (Bea).*

*Breastfeeding was a challenge for her. It was a challenge to be comfortable, tender to sit down on the first week (Bea).*

*She felt the tear impacted on the bonding with her baby (Bea).*

A few midwives reported an increase in women's level of anxiety and concern regarding the healing of perineal tears. Midwives revealed women voiced their concern regarding their perineal health and the physical appearance of the perineum.

*She wanted me to come outside of our normal times that I visit to check her perineum (Rose).*

*She was scared about how long term this was going to be (May).*

*I remember her asking me how it looks how does it look umm and I think although they had talk to her immediately post repair about how it had gone and what it involved*



*she in her head had thought she had torn right down through her sphincter and it was gonna look horrific (Bea).*

Consistent, ongoing midwifery support for women during the postnatal period was valued and appreciated by women.

*She had so many different opinions whenever she came that I guess I was a constant. I was somebody that she could, I could see her untold times postnatally and umm you know she would I could sort of measure the progress because I saw her more regularly. But she also didn't have to explain the situation to different people. (Goldie).*

Midwives described examples where they felt their relationship with women appeared to have strengthened during the postnatal period compared to the antenatal period.

*I felt she needed me, I felt in her world she didn't need me antenatally because it was all on her own terms but postnatally she was dealing with something that she hadn't really considered and I think it threw her sadly and yes, she needed me more (May).*

*Actually, I thought our relationship was better postnatally it got better postnatally, I think she was a bit more serious about what was going on (Goldie).*

A few midwives reveal unexpected complications of SPT overshadowed the positive feelings women initially felt about their positive birth experience.

*I think she was on quite a high that she achieved her vaginal birth, you know [but] she had not taken on board that she was completely incontinent (May).*

*As things became apparent with her healing afterwards and the repercussions of the tear, the conversations change (May).*

*[She was] really surprised quite upset [with being incontinent of urine]. I think she mourned the loss of her bladder control (May).*

Midwives reported complications suffered by women also had an impact on their social life.

*I have to say it has absolutely limited her lifestyle, this injury (Carol).*

*[You] are not gonna go out and your wings are clipped big time (Goldie).*

*Socially she was very compromised by this because if you have no control over your flatus, you know (Goldie).*

According to the midwives, women's decisions regarding the mode of birth for future pregnancies are influenced by SPT sustained, especially if the women suffered ongoing complications during the post-natal period.

*Oh my God I'm doomed, you know I'm gonna have a Caesar every time I'm gonna have a baby. Now that's it, my life is ruined (Goldie).*

*She doesn't want a baby coming through that again (Carol).*

*Her desire to have an intact perineum and an intact rectal muscle was far more important than having a vaginal birth (Liz).*

*If she has another baby, she would choose a caesarean section because she never considered she would incur a perineal tear (May).*

Midwives revealed SPT affects women in different ways. Some women appear to be both physiologically and psychologically affected. This trauma may have long term influence on some women, while others seem to recover sooner. This trauma affects not just the woman but also influence the midwife who provided midwifery care during labour and childbirth.

### 4.2.3 The participant's perception of the effect of SPT on themselves

Midwives are affected by different emotions when the woman in their care sustain SPT during childbirth. Despite these emotions, they continue to provide care for their women. They find different ways to cope and make sense of this event.

#### 4.2.3.1 Guilt and self-blame

Most of the midwives described feeling guilty and blaming themselves for the tear the woman sustained during childbirth. Others questioned their practice.

*I feel anxious about it (Goldie).*

*I felt terrible I blame myself for this (Maria).*

*You always feel a bit guilty at least I do anyway because you think what I could have done differently (Carol).*

*It throws you a bit (Christina).*

In contrast, one midwife reported feeling no guilt or blame for the woman sustaining SPT.

*I don't feel in any way that the third-degree tear was my fault or that I contributed to That so I am quite comfortable with that (May).*

This midwife however described her feelings about not discussing the potential for trauma occurring during birth with the woman.

*That is what I felt sad about that I never really discussed this antenatally with her. You know she was so focused on having a vaginal birth I had never actually said the words what about the fact that you may [sustain] a perineal tear (May).*

All midwives diagnosed the tear and asked a member of the obstetric team to confirm the diagnosis of SPT. Some midwives expressed their happiness and satisfaction at detecting SPT, ensuring the tear can be properly repaired.

*I feel that the important thing is that it has been detected that umm that even if it is a 3A tear that I feel glad that I detected it. I had seen it acted on it and it is going to be properly repaired and that is important (Bea).*

*I am very particular about examining perineum because I think the thing that would be worse than having a third-degree tear would be a third or fourth-degree tear that wasn't recognised you know that would bother me much more (Goldie).*

Midwives describe their feelings of guilt about the trauma sustained is attributed to their awareness of potential ongoing health issues a woman may suffer in the future. Others have concerns regarding not identifying severe perineal trauma and the long-term impact this oversight may have on the woman's future health.

*It is such a game-changer for any of their future sort of care and things like that (Goldie).*

*What if this woman has terrible health problems later in life because of this injury?*

(Maria).

*How would I live with something like knowing I overlooked something that can be detected by a simple inspection (Maria).*

*What if you miss a major tear and the woman has terrible consequences (Maria). it is such a game-changer for any of their future sort of care and things like that (Goldie).*

*What if this woman has terrible health problems later in life because of this injury? (Maria).*

Beliefs and ideology carried along from a midwife's midwifery training influenced her feelings of guilt regarding the trauma sustained.

*In my early years of my midwifery career if someone in your care sustained a third degree tear it was considered poor midwifery support that you were given that you were basically, at fault for what had happened umm, and I know that is not one hundred per cent true (laughing softly). But I still have that etched in my brain, so I always feel gutted when people have a third-degree tear (Goldie).*

#### 4.2.3.2 Loss of confidence

Some midwives reported feeling a loss of confidence fuelled by fear and anxiety after the woman sustained SPT.

*It throws you a bit (Christina).*

*[I] Lose my confidence a bit, I would probably have a little underlying fear that little question what if this happens again (Liz).*

*I was so scared this will happen again that umm I asked a colleague to help this woman with her birth (Maria).*

*I was so anxious so worried I wanted to see what my colleague was doing she has a good record umm she's never had a third-degree tear (Maria).*

*I was so traumatised I wanted to leave midwifery (Maria).*

Midwives described their approach to the next birth were different due to result of trauma sustained in previous woman. This event makes participants examine their practice.

*It makes me go I'm gonna be guarding the perineum and watch it all the way out as baby comes out (Christina).*

*I would probably revisit the delivery of the head and the shoulders you know this absolutely (Liz).*

*I would probably have a little underlying fear, that little question what if it happens again, and I would revisit and rethink you know the delivering of the next woman's baby's head. I would also revisit her positioning either avoiding maybe a birthing stool, avoiding too much gravity. I would certainly strongly consider a water birth and um and very cautiously revisit the delivery of the shoulders because sometimes it is that posterior shoulder the angle that you deliver the posterior shoulder plays a big role (Liz).*

Perineal trauma sustained by women evoked memories of a midwife's own birth experience. Perineal tears suffered during the birth of her children makes this midwife passionate about perineal health for the women in her care.

*Because I have a perineum and had perineal trauma myself, not a third-degree tear but two second degree tears so I know that I would have wanted my midwives to have their hands-on my perineum and, and I do believe that it makes a difference (Bea).*

A midwife described being passionate about women's perineal health as perineal trauma, sustained by a woman in her care, evoked memories of her own elderly mother's unfortunate experience regarding perineal health.

*My mother ended up with a uterine prolapse when she was eighty, and she hadn't thought about that side of herself, and it was horribly embarrassing for her. It was awful you know, and she'd had six children, and she probably was never told anything about pelvic health (Goldie).*

#### 4.2.3.3 Support from colleagues

Midwives report seeking support from midwifery colleagues and felt grateful for the excellent support received.

*The other way it affected me is just how important the kindness of my colleagues was (Maria).*

*Everyone is really open about things around here, and I can talk to practice partners about it (Christina).*

*You need to debrief, and you know, bounce it off others (Liz).*

*[Talking to colleagues] that helps you to process it a bit, especially if you know that other midwives also have third-degree tears regardless of what they have done (Liz).*

#### 4.2.3.4 Examining their practice

Midwives reported changes that occurred in their practice to minimise or prevent perineal trauma in the women in their care. The incidence of SPT in their women also had an influence how they managed the next birth some midwives reported.

*It makes me go I am going to be guarding the perineum and watching it all the way as baby comes out (Christina).*

*So, I may encourage people more to birth in that hands and knees position (Christina).  
I would certainly strongly consider a water birth (Liz).*

*Guarding the head out slowly giving a little bit of resistance, so it doesn't pop out (Christina).*

*I would revisit and rethink you know the delivery of next woman's baby's head (Liz).*

*I feel anxious about it sometimes, I hate the few that I've had umm yea it does, but I don't do episiotomies. I have hardly done maybe half a dozen episiotomies in the last few years. But I am trying to think to myself you know how can I stop this, be more sort of pro-active about it and don't let it happen (Goldie).*

#### 4.2.3.5 Fear of being blamed and receiving negative feedback from women

Fear of being accused by women for SPT sustained during childbirth and receiving negative feedback was a significant concern the midwives reported.

*I can see myself with the woman the other day with the third-degree tear that I might be a bit more over caring (laughing) or over thorough maybe. Doing some extra visits maybe just because I don't want to get bad feedback at the end (laughing). I just want to make sure she is really, happy with my care you know that kind of thing (Christina).*

*In her feedback, you know if you get a bad feedback, you remember. And around that time I haven't got any negative feedback form, she didn't blame me (Carol).*

*It was a positive feedback, there was no reflection on my practice (Liz).  
the husband is a [health professional] and stuff, would they blame me for the tear (Christina).*

A midwife reported she thought that apologising to women may implicate the midwives and give the woman the impression her midwife is to blame or is taking responsibility for the trauma sustained.

*I did say to this recent couple, I am so sorry that you tore I really don't know how that happened and stuff like that. And probably also me saying that might be me justifying a little bit, and possibly me making them think it could be my fault. As well as well because I'm like trying to say oh I am so sorry and lalalalala (making sounds) and it's kind of making it sound like I could have done something different but really, I couldn't so yea I guess I just got to be a bit careful(laughing) (Christina).*

A midwife reported having the impression that women were unaware of how the trauma they sustained negatively impact them as midwives.

*I don't think we tell them I don't think we say I am gutted for you I am Sorry for that, but this is the rationale this is what happened (Goldie).*

A midwife revealed having no fear of being blamed by women when severe perineal trauma was sustained during an instrumental delivery.

*I have just remembered the third degree I had with a ventous, so I had no guilt there*

*because it was a ventouse; it had nothing to do with me (Kristina).*

#### 4.2.4 Long term sequelae of SPT

When a woman booked with the same midwife again after previously sustaining SPT, the midwife became aware of ongoing physical and psychological problems suffered by the woman. These issues surfaced after the woman was discharged from LMC care, and midwives were oblivious to these issues.

*I only discovered this since she rebooked with me, she had her perineum refashioned twice (Carol).*

*When the registrar was suturing her, this is what the lady told me um, she from kinda ten until two the nerves weren't re-joined, and so umm, she has gone on to have incontinence of faeces, so she's seen a specialist in Auckland who was going to do she tells me a nerve implant (Carol).*

*that woman had always been quite scared because she hadn't had her baby with her and she hadn't been able to connect with the baby because she didn't want to go to hospital and here she was in theatre having this operation and didn't see her baby for hours and hours and things (Rose).*

When the woman returned to the midwife for maternity care with her subsequent pregnancy after sustaining severe perineal trauma at a previous birth, the midwife report feeling happy and trusted by the woman.

*So, I mean the fact that the woman has come back to me as her LMC, I guess you could say you know she clearly didn't have a problem with me (Carol).*

*Happy and pleased that she had confidence in me to be involved in her experience again, and her pregnancy and umm I'd say it is a compliment umm yea to be involved and me to it's a real compliment (Bea).*

Midwives described working with women when making birth plans and putting systems in place to minimise the woman's anxiety regarding the place of birth with a subsequent birth after SPT sustained. This was noted by midwives where women sustained SPT in a specific location and feared returning to the same location for the next labour and birth. Following the woman's birth plan ensured she had a positive birth experience with her next delivery.



*she was very anxious about going back to the same birth environment, I said to her, why don't you have your baby at the primary birth unit- I said how about I book you at both units and you don't have to decide until the day and when you labour you just tell me where you want to be at then that is what we do. (Bea)*

*We both knew that there were risks but we were still able to follow the plan that they wanted to and how they wanted to birth and how they wanted to change their birth from their previous experiences. (Rose)*

## 4.3 Conclusion

This chapter outlined the findings found in this research. It provides a discussion on each theme and subtheme, giving insight into how the effects of severe perineal trauma sustained in women during childbirth influence the lead maternity care midwife relationship with women during the postnatal period. Establishing a good relationship and working together in a partnership was vital for the woman-midwife relationship. The relationship maintained strong despite the trauma sustained by women. Women were affected in different ways by the injury sustained at childbirth. All women were affected by fear when separated from their infant soon after birth. Midwives are also affected by trauma suffered by women. Midwives felt a degree of guilt, self-blame, and they feared to receive negative feedback from women regarding their care. These midwives sought collegial support from other midwives. They felt appreciated and trusted when women returned to them for maternity care with a subsequent pregnancy after SPT sustained. Midwives became aware of ongoing health problems some women suffered after discharge from their care. Midwives worked with the women during their subsequent pregnancy to ensure these women have more positive labour and birth experience. The midwives attempted to minimise women's anxiety. The following chapter will discuss the findings in the context of the literature. This chapter will also discuss the implications for future research and the limitations of this study.

## CHAPTER FIVE: DISCUSSION AND CONCLUSION

### 5.0 Introduction

Chapter 4 identified three themes; Establishing a partnership with women, participant's perception of how women were affected by SPT sustained during childbirth, and the effect of SPT on the participants and a fourth theme identified unexpected finding. The study found midwives and women build a relationship based on trust and respect during the antenatal period. LMC Midwives are affected on both an emotional and a professional level when women in their care sustained SPT during childbirth. Women who sustain SPT during childbirth are affected in many ways at different stages during the post-natal period while still under the care of her midwife. Some effects of severe perineal trauma may surface at a later stage once the woman has been discharged from the LMC midwife's care. Those LMC midwives only became aware of those effects when women returned to them for maternity care with a subsequent pregnancy.

This chapter discusses the significance of the themes, given current literature regarding the midwife/woman relationship, and essential factors regarding the importance of this relationship between these two parties. The effects of trauma on women and the impact on midwives' practise will be also be discussed. In ongoing sequelae, I will describe how the SPT sustained in a previous pregnancy impacted on the woman and LMC midwife in preparation for the woman's next labour and birth. Building a relationship and forming a partnership with the woman was identified as a key theme in this study. This theme and the related subthemes will be explored in the following section. Emphasis will be placed on the importance of relationship-building between midwives and women in their care and how trust and respect influence this partnership relationship.

### 5.1 Building a relationship with women

Building a relationship with women was a key theme developed from this study. The midwives identified it was essential to build a relationship with the woman during the antenatal period. The good midwife/woman relationship is necessary for the woman's pregnancy and birth experience (Halldorsdottir & Karlsdottir, 1996). The midwives in this study identify that to know each woman in their care requires the provision of care based on the individual relationship established with each woman (Hunter, 2005). These midwives, therefore, invested both professional and personal aspects of themselves in their relationship with women in their care (Stevens, 2003). At the start of the relationship, midwives had to establish rapport with all women who are new to them. Rapport is vital as communication between the midwife and the woman set the tone for the woman's pregnancy journey (Hunter et al., 2008) and the formation of a

partnership between them. This partnership between the woman and her midwife is based on respect and reciprocity (Pairman,1995). This partnership develops between midwife and woman through their communication, understanding and interaction with one another. The partnership will allow the midwife to identify the woman's needs and desires during the rest of their pregnancy relationship.

Midwives are aware women have different desires and expectations regarding their birth and identify that the quality of the relationship between themselves parties and the women depend on the levels of support the woman will receive from their midwife (Hodnett, 2002). Primigravid women require different levels of support compared to women who have previously experienced pregnancy and childbirth birth. Women put their faith and trust in the midwife to deliver upon their expectations. For the woman, the relationship with her midwife involves feeling safe; for the midwife, it consists in enabling the woman to feel safe and be empowered (Kirkham,2000). Through providing individualised care to each woman, midwives became aware of the woman`s individual needs and wishes regarding her pregnancy care, enabling them to make care plans for the woman`s upcoming labour and birth. The partnership relationships are therefore linked to effective communication between midwife and woman, and this communication is essential for safe practice (Hunter, Berg, Lundgren, Olafsdottir & Kirkham, 2008). The quality of this relationship is attributed to the quality of the communication between them (Hunter et al., 2008).

Through communication, midwives became are that some women were more vulnerable than others and required more emotional support due to anxiety and fear. Where a trusting relationship is established, one-on-one midwifery care is an appropriate approach for dealing with women who display signs of fear and anxiety for labour and childbirth (Lee & Tracy, 2019). Midwives in this study who cared for women showing fear and anxiety reported having to provide more emotional support and constant reassurance to alleviate women`s fear and anxiety. The midwife/ woman relationship is the, therefore, the critical element to on-on- one care midwifery care (Leap et al., 2011). This type of care delivery enabled the midwives to learn about each woman`s needs regarding pregnancy care. Midwives who build good relationships with women in their care reported women came back to them for care during subsequent pregnancies. Knowing the woman from a previously established relationship enabled the two parties to build on the foundations of the already established relationship. Midwives were pleased and felt trusted by these women who return to them for subsequent midwifery care. Despite the efforts of the midwives to build good reciprocal partnerships with women, not all relationships between the midwife and reciprocal.

Two midwives in this study described events where they encountered challenges in building a reciprocal relationship with women. The midwives explained a lack of collaboration between themselves and the women was evident. A lack of cooperation may be a result of a lack of trust and respect (MacGregor & Smythe, 2011). One of these midwives disclosed her relationship with the woman improved as the pregnancy progressed. For the other midwife, however, lack of reciprocity continued through the remainder of the pregnancy, labour and birth. This midwife revealed her interactions with the woman caused her a degree of emotional difficulty and made her feel professionally unsafe (MacGregor & Smythe, 2014). These situations have the potential to influence the quality of care the woman may receive (Hunter, 2005). Challenges for this midwife occurred when the women's wishes regarding her care conflicted with the midwives' beliefs, values and way of practice. This led to the midwife losing trust in the woman. The midwife revealed the women did not fully understand the implications of her choices and how these choices may impact the midwife's practice. When the midwife recognises the ineffective partnership between herself and the woman, a loss of trust in the woman develops, leaving the midwife to feel professionally unsafe (MacGregor & Smythe, 2014). Another midwife in this study revealed the women appeared indifferent to her advice and actions, leading to advice being ignored and disregarded. Hunter (2005) described these situations as a rejection of exchanges. In these instances, midwives had no choice but to uphold the woman's right to free and informed decision and consent (NZCOM, 2008) during pregnancy, labour and birth. The survival of such relationships is threatened when the trust between partners is eroded or breaks down. In these circumstances, the partnership between the midwife and the woman has the potential to become unsafe (McGregor & Smythe, 2014).

By working in partnership with these women, midwives had to recognise her individual and shared responsibilities with the women in their care (NZCOM,2008). These midwives showed respect for the woman's informed choices and decisions. However, the women's decision was in contradiction with the midwife's own beliefs (NZCOM, 2008). The midwife and this woman in her care have an equal status in the midwifery partnership, and information and power are shared (Guilliland & Pairman, 2010). The midwife and women had to work together and negotiated an outcome as the midwives were not the only partner who influenced this relationship (Guilliland & Pairman, 2010). For the midwife, however, there was no mutually satisfactory outcome. This midwife felt the woman had a satisfactory result as she achieved the vaginal birth she wished for, despite sustaining SPT. According to Pelvin (2010), the midwife's role towards the woman is one of "the accompanying, experienced, knowledgeable and supportive presence" (p.7). The midwife had to accept the right of the individual woman to control her pregnancy and birthing experience (NZCOM, 2008). The midwife disclosed the lack of reciprocity she had with the woman made the midwife feel disrespected by this woman.

### 5.1.1 Trust and respect

Midwives revealed they felt trusted by the women in their care. Midwives earn trust through their excellent care, communication skills, compassion showed to women (Calnan & Rowe, 2008). A few midwives reported caring for women who had previously been in their care with a prior pregnancy. As a trusting relationship was established during the previous pregnancy, the midwife and woman could once again have a trusting relationship in the next pregnancy. It is evident that the woman's positive experience of the care she received increased her confidence in the midwife (Calnan & Rowe, 2008). This relationship of sharing between these parties involves "trust, shared control and responsibility and a shared meaning through mutual understanding" (Guilliland & Pairman, 2010, p.7). Midwives viewed this factor as the reason for women returning to them for care with a subsequent pregnancy. Midwives attributed the trust from these women to the support and care received and the woman's satisfaction with her midwife during the previous pregnancy. Maintaining trust and mutual respect with women are vital elements of midwifery care (Lundgren & Berg, 2007). When midwives became aware of women who previously sustained SPT had referred friends and family members to them for pregnancy care, they viewed this as a sign of trust and respect from the woman.

With primigravida women, or a woman new to the midwife, the trust between woman and midwife had to be found as trust cannot automatically be assumed (Lewis et al., 2017). Midwives invest a lot of time to build and establish the woman's trust. Midwives reported their ongoing care of the women's resulted in an increase in the woman's level of satisfaction and subsequently increased the level of trust. When midwives provide women with the opportunity to exercise choice and participate in decision making regarding their pregnancy, labour and birth, the woman's confidence in her midwife grew. This relationship of sharing between these parties involves "trust, shared control and responsibility and a shared meaning through mutual understanding" (Guilliland & Pairman, 2010, p.7).

## 5.2 The midwife's perception of how women were affected by SPT

### 5.2.1 Effects of SPT on women in the first few days following the birth of the infant.

Midwives disclosed all women experienced a degree of perineal pain. For some women, the pain impacting on their ability to sit comfortably and breastfeed the infant. LMC midwives reported women responded in many different ways in the immediate aftermath of sustaining SPT. Other midwife's responses ranged from women feeling euphoria as the women had achieved a vaginal birth and felt nothing else mattered to then

at that stage. Other midwives reported women being stunned by the diagnosis of the perineal trauma. Women's initial perception of their injuries is perceived as indifferent due to the belief that sustaining a perineal tear was a typical outcome of having a vaginal birth (Williams et al., 2005).

### 5.2.2 Fear of being separated from the baby

For pregnant women, attachment to their baby develops during pregnancy, and after the birth of the infant, this continues and develops fully (Wigert, Johansson, Berg & Hellstrom, 2006). After the birth of a baby, the first few hours play a vital role in the mother-infant bonding as this has a substantial and long-lasting impact on the lives of both mother and her baby (Niela-Vilen, Feely & Axelin, 2016). Mother-infant bonding may improve the development of infant cognitive and social skills later in life (Dalsant, Truzzi, Setoh & Esposito, 2015). It may potentially protect the mother from developing post-natal depression (Reck, Zietlov, Muller & Dubber, 2016).

All midwives reported women expressing fear of being separated from their infants when being transferred to the operating theatre for surgical repair of the perineal trauma. Separation of infants from their mothers, when the mother moved to the operating theatre, is standard practise at all hospitals referred to by midwives in this study. When a new-born baby is separated from its mother, the mother feels disappointed after the intense emotional experience of giving birth, and the mother may experience a loss of trust (Bondas-Salonen, 1998). Separation from their infants prevented mothers from having ongoing skin-to-skin contact with their new-born infant. Midwives reported encouraging skin to skin contact between mother and infant, ensuring the mother had contact with her baby before the separation from her infant occurred. The World Health Organization (2013) recommend that mother-infant closeness be supported and maintained through skin to skin contact and consider this to be beneficial for both. The woman's positive birth experience is entrenched in her awareness that her midwife showed compassionate and respected her during labour and birth (Halldorsdottir & Karlsdottir, 2011). By allowing skin to skin contact before separation from the infant compassion and respect towards the mother continued in the aftermath of the birth.

### 5.2.3 Participants' impression of how women were affected during the next six weeks after sustaining SPT

Midwives in this study gave various accounts of how women coped during the postnatal period while still under their care. Women who had no ongoing health problems appeared to be minimally affected by perineal trauma and healed without further complications. Midwives revealed some women continued to suffer perineal pain. Perineal pain can turn breastfeeding into a difficult task (Way, 2011). Breastfeeding

provides a vital emotional connection between the mother and her baby. Problems with breastfeeding have the potential to influence a woman's level of anxiety (Hegley et al., 2008).

Midwives described women who experienced an increased level of anxiety regarding the physical aspects of the perineum. One midwife explained the concerns of a woman who feared the SPT might have disfigured her perineum. According to Priddis (2015), women who suffered SPT may experience an altered perception of their body image. The midwife described ongoing support, constant reassurance, and more frequent visits than anticipated helped alleviate this woman's fears regarding the physical appearance of her perineum.

Midwives described some women experiencing other complications attributed to SPT. Midwives gave accounts of two women who experienced urinary incontinence during the immediate post-partum period. Women who suffered urinary and faecal incontinence described their bodies as being contaminated and uncontrolled (Priddis, 2015). One midwife explained the women's feeling of shock when urinary incontinence was diagnosed. Women who suffer incontinence after sustaining SPT feel their bodily functions is out of their control (Priddis, 2015). Midwives in this study revealed accounts of women being afraid to leave the house due to urinary incontinence According to Williams et al. (2005) women affected by urinary incontinence might experience feelings of being isolated (Williams et al., 2005).

Two midwives described how the ongoing health problems experienced by two women altered their relationship with the women during the postnatal period. Both these midwives disclosed their relationships with these women during the antenatal period was not very good. These midwives concluded the relationship changed during the postpartum period. For these midwives, a reciprocal partnership developed with these women during the postnatal period. For these midwives, it was important for women to acknowledge their help. The women's feeling of being needed was viewed as a recognition of the midwives' role (Mc Crue & Crude, 1991). These midwives attributed changes in their relationship with the affected women to their constant and unfailing support during the postpartum period. These women appreciated the attentiveness and unwavering support and care from the midwives who remained friendly, positive and compassionate. The midwives ensured that women-centred care remained their focus (Mc Kellar et al., 2006).

## 5.3 Participants' perception of how the SPT sustained by women affected themselves

The midwives reported SPT suffered by women in their care had an impact on them on both professional and personal level. Most of the midwives in this study reported having feelings of guilt and self-blame following childbirth where the women sustained SPT. Only one midwife in this study disclosed feeling no guilt or self-blame for SPT sustained by the woman in her care. One midwife described being traumatised by the birth where the woman sustained SPT. Midwives are the guardians of normal birth (Fahy et al., 2008) and while midwives most often facilitate positive and uplifting births (Rice & Warland, 2012) events such as SPT may curb the midwives' satisfaction. These events may lead to midwives feeling personally responsible for injury sustained by women during childbirth.

### 5.3.1 Guilt and self-blame

Only one of the midwives in this study reported no feelings of guilt and self-blame when women in their care sustained SPT during childbirth. In the aftermath of an adverse event affecting the woman in their care, midwives often experience feelings of guilt without being at fault (Schroder et al., 2017) Midwives reported being fearful of the ongoing effects the women may suffer as a result of SPT sustained during childbirth. Midwives revealed their knowledge of potential morbidities in these women was responsible for their feelings. The midwife's feelings of guilt and self-blame may be attributed to her connecting not just with women but also with her unborn baby. The midwife also forms a connection with those who are significant to the mother (Halldorsdottir & Karlsdottir, 2011). Midwives may perceive injuries sustained by women as a betrayal of both the woman's trust as well as the trust of others in the woman's life (Halldorsdottir & Karlsdottir, 2011). The work of the midwife has been described by Pezaro et al. (2016) as being emotional and traumatic.

Events that cause psychological distress may be viewed as insignificant and a normal part of the midwife's daily work environment (Wallbank & Robertson, 2013). When the midwife experiences an unpredictable and uncontrolled situation, like SPT sustained by women, it can lead to an increase in their level of stress. The midwives response may be caused by interactions with the woman and her family, who may blame her for the injury sustained. Pressure may increase if the midwife is singled out and criticised by the woman and midwifery colleagues, and make her feel unprofessional (Dahlen & Caplice, 2014). A few midwives revealed women being oblivious to how these events affect the LMC midwife. According to Tracey and Roberts (2004), feelings of guilt and shame relate to experiences of not being good enough. Guilt and shame are part of our most secret and concealed feelings (Tracey & Roberts, 2004).



These feelings of guilt and self-blame also surfaced as they feared they might have betrayed the woman's trust. This finding is in contrast to the study by Edqvist et al. (2014). They found midwives' feelings of guilt and self-blame may also be attributed to fear of being responsible for separating the woman from her infant and her partner when the woman transferred to the operating theatre for surgical repair of perineal trauma. These feelings experienced by midwives may negatively impact on their belief in themselves and negatively influence their practice (Edqvist et al., 2014).

### 5.3.2 Loss of confidence

Midwives revealed experiencing loss of confidence in their professional ability when a woman in their care sustains SPT. A loss of confidence in their professional ability creates difficulty in caring for another woman in labour (Pezaro et al., 2005). A few midwives reported when becoming fearful during labour and childbirth. One midwife felt her feelings of fear might cause her care of the woman to be less effective. Fear in the midwife may incite feelings of anxiety and anxiety may negatively impact birth outcomes (Pezaro et al., 2015). According to Sheen, Spiby & Slade, (2015), any event deemed by the midwife to involve a risk to the woman or the infant may potentially evoke her feelings of fear, helplessness and horror. These events led midwives to examine their practice.

### 5.3.3 Examining their practice

Midwives in this study, midwives reported examining their practices and considered adopting other measures to minimise the risk of SPT in other women in their care. The midwives report they carefully examined every detail of the labour and birth leading up to the time the woman sustained SPT. They searched for reasons why the injury occurred and discussed how they managed the second stage of labour against what they could have done to prevent this damage. Midwives examine their practice after a traumatic experience to make sense of this event. Considering the facts is conducted to decide if they carried any personal responsibility (Schroder, La Cour, Jorgensen, Lamont & Hvidt, 2017) for the perineal tear occurring. The midwives reported reflecting on the event provided them an opportunity to evaluate their practice and examine what lessons they could learn from this event. Some midwives relayed this led them to adopt changes in their management of the next woman's birth. Midwives disclosed changing their practices and adopted different procedures to minimise the incidence of this injury in other women in their care. The midwives reported these changes ranged from guarding the perineum to trying different birth positions. Midwives sought support from their colleagues to help them reflect and find answers.

### 5.3.4 Seeking support from colleagues

Caring for women who are experiencing suffering, pain, and trauma can cause traumatic stress reactions in the midwife (Rotschild,2006). Ongoing exposure to an emotional and traumatic work environment or events in a situation where the midwife is unsupported can give rise to psychological and behavioural problems for the affected midwife (Pezaro et al., 2016).

Midwives relayed how they dealt with the cause and insecurities of their fears in the aftermath of SPT. Midwives sought support from other midwifery colleagues. Midwives reported discussing the event with midwifery colleagues. Seeking collegial help and advice allowed the LMC midwife to reflect and gain some perspective on the circumstances and enabled them to work through feelings of guilt and self-blame. According to Skinner (2011), it is beneficial to a midwife's practice to maintain supportive, honest and meaningful midwifery relationships with other midwives. There are many benefits of trusted midwifery colleagues sharing and supporting one another. This sharing grant midwives an opportunity to reflect, obtain guidance, advice and gain an understanding. This will enable the midwife to feel empowered (McGreg & Smythe, 2014). Seeking support from colleagues can also be an attempt by the midwives in this study to "support and sustain midwifery practice" (Gilkison & Hewitt, 2019.p 282). Seeking this type of support from others is vital as the support from midwifery colleagues allowed these midwives to maintain their physical and emotional health (Gilkison & Hewitt, 2019). Supportive relationships between supportive midwifery colleagues are essential for the emotional and physical wellbeing of midwives affected by adverse events ( McGregor & Smythe,2014). According to Edqvist et al. (2014), midwives feared being exposed and judged by their peers, and this may often prevent them from sharing their experiences with their midwifery colleagues. Midwives in this study, however, found sharing their experiences with a trusted midwifery colleague to be beneficial as this helped her reflect on the event and her practice.

### 5.3.6 Diagnosing SPT

Midwives reported being pleased they identified the perineal damage and referred woman for review by a member of the obstetric team. The midwives were aware that mismanagement, incorrect diagnosis, and inaccurate repair of perineal tears might have severe consequences and adversely impacted the affected woman's health (Jaiyesimi, 2007). Any midwife who has uncertainty about the extent of a perineal tear should seek a second opinion from a midwifery colleague or experienced doctor. This is necessary as bleeding and swelling of the perineal tissues have the potential to make the diagnosis of perineal tears difficult (Jaiyesimi,2007). Midwives, however, feared the woman might be displeased and provide negative feedback regarding sustaining SPT during childbirth.

### 5.3.7 Fear of negative feedback

While women prepare for the birth of their infant, they build an impression of what is and is not expected to occur during labour and subsequently, during the postnatal period. Part of this image includes the extent of any perineal damage that may arise (Way, 2011). Any event or trauma that occurs during childbirth may be reasonable by the midwife but not by the women's standards and circumstances (Way 2011).

Midwives reported that feelings of fear surfaced in expectation of being blamed by women in the form of negative written feedback. Some midwives revealed to receive negative feedback from women would confirm women blame them for the perineal trauma sustained. According to Dahlen & Caplice, (2014), the impact of midwives' fear on their practice and the effect on the women are unknown. However, anxiety may impact on the midwife's level of stress and lead to burnout (Dahlen & Caplice, 2014).

A few midwives feared when women blame them for the birth trauma sustained, and the women may persuade others not to seek pregnancy care from them. Midwives were concerned they may be labelled as incompetent by women. These events may potentially lead to a decrease in their workload and loss of income. According to Dahlen & Caplice (2014), midwives fear being watched, criticised, persecuted and judged by women and their peers. Negative interactions involving the judgement of her performance and abilities can threaten her self-worth (Kudielka, Hellhammer & Kirchbaum, 2007).

When women evaluate their birth experience, two critical factors are regarded as necessary by women. These factors are their relationship with their midwife, and the amount of midwifery support received (Hodnett, 2002). None of the midwives in this study received any negative feedback from the women who sustained SPT during childbirth. The midwives in this study perceived this to indicate these women did not blame them for SPT suffered. They believed the women were satisfied with the midwifery care received. Midwives who experience exposure to trauma in childbearing women have the potential to develop secondary traumatic stress (Leinweber & Rowe, 2008). Secondary traumatic stress refers to the emotional stress resulting from the midwife's exposure to multiple traumatic events as well as women and their partners traumatised by childbirth (Leinweber & Rowe, 2008). Pezaro, Clyne, Turner, Fulton & Gerada (2016) found that midwives who experience work-related psychological stress have the potential to provide poorly for women in their care. Midwives have reported becoming fearful during a birth. They thought their care of the woman was less effective as their anxiety may have negatively impacted on birth outcomes (Pezaro et al., 2016). Midwives described being the cause of a negative birth experience as one of their worst fears (Dahlen & Caplice, 2014). Missing something that may cause harm, losing their passion and their confidence around normal birth were described by Dahlen & Caplice (2014) as factors that contribute to midwives' fear.

## 5.4 Ongoing sequelae

Three midwives reported women who previously sustained SPT returned to them for midwifery care with a subsequent pregnancy. Returning to the same LMC midwife who provided care during the woman's previous pregnancy, indicate the woman's need for continuity of care (Siguroardottir, Gamble, Guomundsdottir et al., 2019). During the subsequent pregnancy, the midwives became aware of physical and psychological health issues that surface after discharge from midwifery care. Their lack of knowledge regarding these health issues after discharge from their care was due to the short duration of postnatal maternity care.

Women felt comfortable disclosing this information to the midwife. Disclosure to an understanding and empathetic person can be an emotional experience for some individuals (Gamble & Creedy, 2004). As these women had previously built a relationship with the LMC midwife, they trusted the midwife who would now support the specific needs and visions they required for their next birth (Thomson & Downe, 2010). These women sought supportive pregnancy care from a midwife who understands her needs. They believed continuity of midwifery care is essential to provide quality women-centred care (Renfrew et al., 2014) from a known and trusted midwife. Midwives are aware that mutual trust, respect and reciprocity are of vital importance to this healthy relationship (Leap et al., 2011). Midwives in this study recognised the previous one-on-one care, and the excellent relationship previously established influenced these women's decision to return to them for midwifery care. Midwives gave accounts of the women becoming anxious as the pregnancy progressed.

Childbirth involves substantial emotional work for women (Edwards, 2009). Pregnancies often reignited emotional distress caused by unpleasant experiences during a previous pregnancy (Thomson & Downe, 2010). Pregnancy may increase the woman's vulnerability and complicate the ability to resolve previous negative birth experiences (Edwards, 2009). For the midwives, it was essential to alleviate these women's fears and ensure a positive birth experience. Through their continuity of care to the women, the midwives were in a position to focus on reducing women's risk of repeat birth trauma (Simpson & Catling, 2016) during the subsequent birth. The elements vital to assist women in achieving a satisfying birth experience are the quality of care, excellent communication between woman and midwife and the sharing of essential information regarding pregnancy, labour and birth (Thomson & Downe, 2010). The midwives relayed during the subsequent pregnancy; they validated the women's distress by listening to them and acknowledging their fears and requests for the next birth (Thomson & Downe, 2010). Midwives relayed this involved negotiating extensive birth plans with women to reduce the risk of a repeat occurrence of perineal trauma. Midwives revealed these women required constant reassurance and support during the subsequent

pregnancy. It was important for these midwives to assist the women in gaining control, enhancing their confidence and facilitate their empowerment after the previous birth (Thomson & Downe, 2010) where the woman sustained SPT. Midwives reported the quality of their relationship and decisions made with women caused crucial differences to these women's subsequent birth experience (Thomson & Downe 2010). During the subsequent births, none of these women sustained a repeat incidence of SPT. One midwife revealed a woman requesting a caesarean section for her next delivery as this woman still suffered ongoing health problems and feared a repeat incidence of SPT.

## 5.5 Limitations and Strengths

Limitations of this study were the small sample size of only eight LMC midwives. During this study, no women were interviewed. It would be interesting to get the perspective from women who sustained SPT during childbirth on their relationship with their LMC midwife. The strength of the study is the participant sample interviewed. The study participants practice midwifery in three different geographical locations on the lower North Island of New Zealand, ensuring a perspective was obtained from a variety of midwives.

## 5.6 Implications for Practice

The study found that midwives value the relationship established with women while providing her care during pregnancy. Midwives are deeply affected when women in their care sustain SPT during childbirth. Midwives rely on their midwifery colleague for advice, guidance and emotional support when involved in an unexpected or traumatic event. No formal support structure is in place to support the midwife who experiences the incidence of SPT in their women. Midwives should be encouraged to seek help and talk to their peers and midwifery colleagues who can supply support and advice in a non- judgemental and supportive environment.

The RCOG (2015) stipulates that all incidences of third and fourth-degree perineal tears should be repaired in the operating theatre. Repair of SPT may, however, be performed in the delivery room in certain circumstances after discussion with a senior obstetrician (RCOG, 2015). This is an option that can be explored by the LMC midwife in consultation with the obstetrician on duty. Where possible, this may prevent unnecessary separation between mother and infant when the mother transfers to the operating theatre for the repair of SPT. Support structures for midwives should be implemented, allowing both LMC and core midwives to seek support from colleagues when adverse events occur.

## 5.7 Recommendations and implications

Maternity units in New Zealand should review the policy around separating mothers from their infants when the woman is transferred to the operating theatre for surgical repair of the perineum. The partner or another support person could potentially accompany the mother and her infant to the operating theatre. This support person could hold the infant in full view of the mother while a member of the obstetric staff is performing perineal suturing. This practice would not differ from what occurs currently in hospitals in New Zealand. During a caesarean section, a support person is allowed to accompany the woman to the operating theatre. The support person is present during the entire procedure. The support person is allowed to hold the baby in full view of the woman if she does not want to engage in skin to skin contact with her infant.

No women who sustained severe perineal trauma during childbirth were interviewed. The woman's perspective on her relationship with the LMC midwife would give midwives an insight into the woman's feelings and experiences regarding her relationship with her LMC midwife. Women's experience would be an interesting research topic to explore.

## 5.9 Conclusion

Midwives are affected on different levels when a woman in their care sustains SPT during childbirth. Some midwives were traumatised after the event; others blamed themselves for the trauma suffered by the woman. Only one midwife did not feel responsible for the woman sustaining SPT during birth. The midwives examined their practice to determine what caused the tear and what measures they can employ to prevent such injuries in the other women in their care. The midwives coped with this event by speaking to midwifery colleagues. These conversations provided them with an opportunity to reflect and learn. Midwives value the support from their colleagues.

During the antenatal period, midwives and women build partnerships that were maintained throughout the woman's pregnancy journey. This partnership was built on the foundation of trust, respect and reciprocity between midwives and women in their care. Most midwives described a good relationship existed between themselves and the women in their care. Two midwives described relationships with women during the antenatal period that was not satisfactory. Despite the trauma sustained during childbirth, the midwives who had good relationships with their women during the antenatal period continued to have a good relationship with the women during the post-natal period. The midwives who did

not have a good relationship with women during the prenatal period disclosed the relationship improved during the postnatal period. The midwives attributed this to the ongoing support they offered the women.

The midwives feared negative feedback from the woman regarding sustaining SPT during childbirth. They perceived this as blame from the woman for the trauma sustained during birth. Although midwives feared the women would blame them for the injury sustained, the relationship maintained stable and unchanged for most midwives. Some women returned to the midwife for pregnancy care for a subsequent pregnancy. This enforced the midwife's belief that women did not blame them. They felt the woman trusted their care and professional practice. The midwives who did not have a satisfactory relationship with women during the antenatal period described becoming aware of a change in the relationship during the postnatal period. These midwives were of the impression that the relationship improved during the postpartum period. They attributed this to their constant, unfailing support for these women during the postnatal period. None of the midwives in this study received negative feedback from the women.

## APPENDICES

### Appendix 1 – Ethical Approval



Phone 0-4-463 5480  
Email susan.corbett@vuw.ac.nz

#### MEMORANDUM

TO	Audrene Samuel
COPY TO	
FROM	AProf Susan Corbett, Convener, Human Ethics Committee
DATE	7 February 2018
PAGES	1
SUBJECT	<b>Ethics Approval: 25513</b> The effects of perineal trauma sustained during childbirth on the relationship between the Lead Maternity Care Midwife and the woman.

Thank you for your application for ethical approval, which has now been considered by the Standing Committee of the Human Ethics Committee.

Your application has been approved from the above date and this approval continues until 7 February 2021. If your data collection is not completed by this date you should apply to the Human Ethics Committee for an extension to this approval.

Best wishes with the research.

Kind regards



Susan Corbett  
Convener, Victoria University Human Ethics Committee







## **Invitation To Lead Maternity Care (LMC) Midwives**

**Are you a Lead Maternity Care (LMC) Midwife?**

**Have you ever cared for a woman in labour where the woman sustained a third-or fourth degree perineal tear during childbirth?**

**Come talk to me about your experience(s) of caring for women who sustained severe perineal trauma during childbirth.**

**My name is Audrene Samuel. I am a midwife. I am enrolled as a student at Victoria University of Wellington Post Graduate School of Nursing, Midwifery and Health. This research is for a thesis towards a Master of Health Care (Midwifery Practice).**

**This research aims to look at the effect of severe perineal trauma on the relationship between the Lead Maternity Carer (LMC) and the woman when the woman sustains a third- or fourth-degree tear during childbirth.**

**I will come to you for a confidential interview at a location chosen by you, at date and time suitable to you.**

**The interview process will include open ended questions and a taped interview. There is no requirement to identify yourself or the woman during this interview. All details are strictly confidential.**

**Once I have interviewed you, you can withdraw from this study any time before 31 December 2018.**

**I will provide a summary of your interview before the withdrawal date as stipulated above.**

**The results of this study will be also be published in the New Zealand College of Midwives journal.**

**For more information contact me**

**Email: [samuelaudr@myvuw.ac.nz](mailto:samuelaudr@myvuw.ac.nz)**

**My research supervisor Dr Robyn Maude: [robyn.maude@vuw.ac.nz](mailto:robyn.maude@vuw.ac.nz)**

**This research has been approved by the Victoria University Human Ethics Committee. Ethics Approval number: 0000025513 and endorsed by Nga Maia o Aotearoa Maori Midwives.**

## Appendix 4 Consent to interview



### **Effects of Severe Perineal Trauma during childbirth on Lead Maternity Care (LMC)**

**Midwife/Woman**

**Relationship**

#### **CONSENT TO INTERVIEW**

**This consent form will be held for 5 years.**

**Researcher: Audrene Samuel**

**Graduate School of Nursing, Midwifery and Health**

**Victoria University of Wellington**

I have read the Information Sheet and the project has been explained to me.

My questions have been answered to my satisfaction. I understand that I can ask further questions at any time.

- I agree to take part in an audio recorded interview.

I understand that:

- I may withdraw from this study at any point before 31 December 2018, and any information that I have provided will be returned to me or destroyed.
- The identifiable information I have provided will be destroyed on 30 November 2024.

Any information I provide will be kept confidential to the researcher and her supervisor.

- I will not use the name of my clients or colleagues during the interview
- My name will not be used in reports, nor would any information that would identify myself, my clients, or my colleagues
- I would like a copy of the recordings of my interview  
Yes NO
- I would like a copy of the transcript of my interview  
Yes NO
- I would like a summary of my interview  
Yes NO
- I would like to receive a copy of the final report and have added my email address
- I am aware that any disclosure of information that relate to any act of a serious nature may, under due circumstances, be subjected to due process of the law.
- I understand that the results of this study will be used for a master's thesis

Name of Participant \_\_\_\_\_

Signature of Participant \_\_\_\_\_

Date:

Email:

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