A WOMEN-CENTRED EXPLORATION OF POSTPARTUM PERINEAL PAIN WHEN THE PERINEUM IS DIAGNOSED AS INTACT: A FRENCH GADAMERIAN RESEARCH STUDY

Abstract

Background- Postpartum perineal pain is a frequent symptom (90%) with consequences on postnatal health regardless of whether the perineum remains intact. The impact of that pain on both short and long-term health has been studied and literature suggests midwives have a role to play in addressing this issue. However, the determinants of perineal pain in the absence of vaginal lesion are under researched and there is little understanding of women's views on this topic.
Aim and objectives- The aim of the study was to gain an understanding of postpartum perineal pain when the perineum is considered to be intact. The objectives were

- To gain an understanding of postpartum pain and its consequences on health and well-being
- To explore women's views and understanding of perineal pain postpartum
- To gain an understanding of the determinants of postpartum perineal pain when no anatomic lesion is diagnosed.

Methods- A Gadamerian hermeneutic approach was used to achieve a shared understanding of the issue. Participants were recruited from two maternity hospitals in the French area of Vaucluse. All women aged 18 to 45 years old, having given birth vaginally to a single live child and diagnosed with an intact perineum, were invited to participate in face-to-face interviews. Eleven participants were interviewed once, six of whom agreed to a second interview which took place over the telephone due to Covid lockdown.
Findings- The findings identified three major themes 1. Can't honestly call it pain, 2. Reassurance in normality, 3. Managing the unexpected. The use of the word pain to describe perineal sensations in postpartum was questioned by the participants, who used inner resources to deal with these sensations. Fostering self-confidence, having the possibility to explain the sensations and qualifying them as normal were some helpful capacities for women to manage their postpartum perineal sensations in a positive manner.

Keywords

postnatal pain, midwifery, perineal pain, intact perineum, postpartum, experience, empowerment

Introduction

Table 1. Statement of significance

Pain is defined by Dahlke et al (2017 p.158) as 'an unpleasant sensory and emotional experience associated with actual or potential tissue damage or described in terms of such a damage'. In obstetrics and midwifery, similarly to other clinical specialties, addressing the issue of pain has become a core aspect of care (Craig et al 2015). National and international organisations have stated the right to pain management as a human right and a means of evaluating quality of care (Haute Autorité de Santé 2007, Craig et al 2015). Pain in general, and perineal pain in particular, is an extremely common occurrence following childbirth, alongside uterine contraction pain, back pain and breast cracks (MacArthur and MacArthur 2004, Neels et al 2017). Some quantitative studies state that around 90% of women experience perineal pain after vaginal birth, including in the absence of perineal injury (MacArthur and MacArthur 2004, Andrews et al 2008); this suggests that determinants, other than anatomic lesion, influence perineal sensations (Andrews et al 2008). Moreover, the consequences of this perineal pain are believed to have an influence on many aspects of a woman's health following birth, such as: breastfeeding; bonding with child; ability to perform daily tasks; and mental health, including a relationship between postnatal depression and higher levels of pain (Chang et al 2016). Perineal pain management will, therefore, have an impact on health as a whole, as described by the WHO as 'a complete state of well-being, physical, mental and social' (WHO 1948), which is why it is an important topic to address in perinatal health. Therefore, perineal pain was chosen as a point of focus of this study, as it is the most frequently reported localisation of pain postnatally (MacArthur and MacArthur 2004, Pereira et al 2017).

Midwives, especially in France, where the study was conducted, are at the forefront in perinatal pain management, as they intervene in hospital settings during labour and immediately postpartum but are also qualified to provide postpartum care and to conduct perineal rehabilitation

sessions (which are advised for every woman and reimbursed by social security). In France, midwives are also qualified to perform gynaecological routine check-ups and smear tests and provide contraception (Code de la Santé Publique 2009). All these points of contact are opportunities for women to raise the topic of postnatal perineal pain, however there are no standardised guidelines on how to prevent and treat this symptom. This lack in practical recommendations for such a frequent symptom was the starting point of this research. In order to produce practical recommendations regarding on management of postnatal perineal pain, it is important to have an understanding of the phenomenon at stake, specifically of its determinants, other than anatomic lesion.

There is little data on the issue of perineal pain when the perineum is intact, however, other fields of health, such as the research around pain in military war veterans have investigated alternative determinants of pain (Outcalt et al 2014). Power et al (2016) identify that relationships are often demonstrated between alternative elements such as mental health, emotional state, resilience, confidence, and pain. Power et al's (2016) point of view, coupled with the studies that show that perineal pain can exist without any vaginal lesion (Andrews et al 2008, Chang et al 2015) leads to consider the possibility that in perinatal health also, pain is multifactorial and needs to be managed as such to prevent, manage and treat postnatal perineal pain (Andrews et al 2008). Available literature on perineal pain suggests that, similarly to other types of pain, the factors influencing postnatal perineal pain could be classified into two groups: mechanical and hormonal factors on one hand; and mental health and emotional elements on the other citations (Chang et al 2015, Pereira et al 2017). The literature also highlighted the existence of confounding factors, confirming pain is a multifactorial issue and that there may be alternative determinants to it that we need to address for better care postpartum. However, there were no studies exploring the women's perspective which sustains a practitioner-led understanding, by focusing on determinants chosen by research teams. The literature comprised of studies conducted worldwide (see table 2), however none originated from France where this study was conducted and none focussed specifically on intact perinea. Therefore, there was a clear

gap in knowledge that justified the need for further research, in order to improve perineal pain management.

Table 2- Summary of literature review

The study set out to provide an in-depth understanding of postpartum perineal pain in the case where the perineum is diagnosed as intact. The objectives were in cases when the perineum is diagnosed as intact:

- To gain an understanding of postpartum perineal pain and its consequences on health and well-being
- To explore women's views and understanding of postpartum perineal pain
- To gain an understanding of the determinants of postpartum perineal pain

Methods

Research paradigm - This research employed a qualitative stance, using Gadamerian research methodology to underpin the research process (Gadamer 1975), which aims at reaching a shared understanding through dialogue with participants. This choice was guided by the nature of the topic at hand and the research area: pain is an individual and subjective experience (Craig et al 2015) and hermeneutical inquiry is appropriate to study individual experiences (Moules et al 2012). The aim of midwifery care, in the case of a normal pregnancy and labour, is not to tell women what to do but find a common path to follow (Hall 2012). Miles et al (2013b) started to introduce the concept of evidence-informed midwifery, as opposed to evidence-based midwifery, shifting from a recommendation's perspective to a women-led perspective. Knowledge, in that case, consists of fully understanding the woman and providing a response that encompasses scientific data, medical recommendations, and individual experience and expectation, so as to co-create a unique experience that will be a positive experience for the woman (Hall 2012). In terms of research methodologies, this seemed best reflected

by a Gadamerian hermeneutic research approach, which was the chosen methodology to underpin this research study. A Gadamerian methodology seeks to reach a share understanding and builds on the basis of prior knowledge by the researcher (Gadamer 1975), which enabled a combination of practical knowledge, existing literature and the research findings to suggest a new understanding of the issue.

Researcher characteristics and preunderstandings- The lead author was a practicing midwife for 12 years before undertaking this research. Her background in public health, made her aware of the multifactorial nature of health and well-being, and open to the idea of alternative determinants of pain. She worked as a community midwife in France, where midwives not only provide care for women in the perinatal period, but also tend to their preventative gynaecological care and perineal rehabilitation. This specific context led to the research question based on the long-term relationship with women encouraging them to disclose intimate issues, such as perineal pain following childbirth. While her prejudices regarding the topic at hand might come in the way of meeting participants' true understanding, using a hermeneutic methodology enabled her to identify these preunderstandings clearly and take them onboard to be challenged by the dialogue with participants. Some of these preunderstandings were that mechanical elements would influence perineal pain - such as long duration of labour, duration of pushing, pushing technique or position. It was also believed that alternative elements such as tiredness, previous history of perineal pain, and emotional state would be additional factors of pain.

Context- Data collection took place between September 2019 and April 2020 and access was granted to recruit participants in the maternity hospitals of Orange and Carpentras in the administrative area of Vaucluse, France. Given the sensitive nature of the data collected, and the timing of inquiry, in line with Schrems (2014), careful attention was given to ethical considerations in order to protect anonymity, ensure informed consent and protect participants from harm. This was achieved by providing thorough information in an oral and written format and recruiting in a manner

that enabled women some time before consenting to participate. Data was stored in password protected files, and participants' identity protected by the use of pseudonyms and removal of any details that might have led to identification. Ethical approval was granted by Avignon Hospital Ethical Board in November 2018 and Glasgow Caledonian University in January 2019. An amended research protocol was submitted following the Covid-19 outbreak in order to change data collection from face-to-face to telephone interviews. This was accepted on April 9th, 2020.

Sampling- Purposive sampling was used to recruit the participants, , All women between 18 and 45 who gave birth vaginally to a single live child and identified as having an intact perineum were eligible to participate in the study. They were approached in person by the lead author during their maternity stay, which lasts 3 to 5 days in France (Coulm and Blondel 2013). Women who considered participating were given an information sheet and provided with contact details. A month later, to allow time to provide consent outside the period of vulnerability that is immediate postpartum (Sandelowski 1995, Schrems 2014), women who had provided their contact details were contacted to organise a face-to-face interview. The numbers of women in each step are in Table 3, with a final sample of 11 women, characteristics outlined in table 4. A first set of interviews was conducted between 1 and 3 months postnatally, to gain a first understanding of the topic. Participants were offered a second interview, which took place between 6 to 8 months postpartum, for the six women who agreed. This took place over the telephone since at that point, lockdown was in place in France due to the Covid-19 outbreak.

Table 3- Summary of recruitment process

Table 4- Participant characteristics

Data collection- As directed by Gadamer's (1975) principles of hermeneutic research, the interviewer's preunderstandings were first identified in order to confront these understandings during the data collection stage. This was achieved through diary writing and conversations with a peer.

Subsequently, a dialogue between the researcher and the participant took place and was followed by a dialogue between the researcher and the text, as proposed by Fleming et al's (2003) framework. This ongoing circle of conversations, dialogues and reflections is the process through which the preunderstandings that are initially identified on the topic, are then questioned and nourished by the research process (Moules et al 2015). Initially data was collected through face-to-face interviews, all of which were audiotaped and transcribed verbatim in French. To preserve the openness required by Gadamerian hermeneutic research (Gadamer 1975), the first set of interviews were unstructured. Women were alone with their baby in seven interviews. Four interviews took place in the presence of another person: one in the presence of the husband, two with the presence of the mother, and one with the presence and active participation of the husband in the interview.

The unstructutred interviews were open conversations beginning with the question: 'Can you tell me about your experience of postnatal perineal pain?'. The purpose of this research, through the use of hermeneutics, was to question previous assumptions by gaining a better understanding from women's perspective, keeping an open mind and avoiding influencing women's stories to better achieve the aim (Moules et al 2015).

Data analysis- The first round of interviews was reviewed and transcribed no more than a few days after the interview took place, and field notes helped described the context of each interview. A reflective diary of understandings was continued and regularly updated during the research process. This was rendered necessary by the fact that the interviewer's understandings were changing even before the data was analysed, and that it was important to track these changes to document this ongoing process (Fleming et al 2003). Following this, each individual interview was coded, and participants were provided with a summary of the conversation. This was written as a four-part account including: storyline, nature of perineal pain, determinants of perineal pain, and reflective statement. Participants were invited to comment and correct any misunderstandings in writing, thus performing member checking (Birt et al 2016). A second round was conducted over the phone using

semi-structured interviews between 6 and 8 months postpartum. For the second interviews, despite the fact that this was over the telephone, fieldnotes were used to describe the context as well as it provided information about the way that lockdown was experienced (Were the women alone all day? Did they have to work remotely or not? Did their partners have to work?). The data was analysed using Fleming et al's (2003) five steps for a Gadamerian hermeneutic analysis.

Findings

The analysis of both sets of interviews yielded three themes: 'Can't honestly call it pain', 'Reassurance in normality', and 'Managing the unexpected', which will be discussed in turn in this section.

'Can't honestly call it pain'

This theme is best illustrated by the following quote by Christelle who said: *'oh dear honestly I would not be able to define it. I wouldn't be able to find the words for it'*. This theme was discussed by all participants who expressed how postpartum perineal pain was not like any other pain or sensation, for a variety of reasons. They used different words to describe the sensation and felt uncomfortable using the word pain to qualify what they experienced.

Four sub-themes were identified, three of which are elements that contribute to explaining that specificity: 'a unique sensation', 'unexpected looseness', 'not that limiting'. The sub-theme 'a unique sensation' describes the other ways to account for the nature of perineal pain: "sensation", "itching", "burning", were some of the words that participants used to explain their experience. 'Unexpected looseness' was mentioned by the participants as a sensation that they had that was not pain but was equally, if not more, disturbing: *'It felt like the organs would fall out really. Something like a weight that I did not experience for my first'* (Louisa). The fact that the participants had an intact perineum may have influenced this sub-theme, as intact perinea are more often found in multipara (Rodriguez et al 2019), who were a majority of the participants), who are more at risk of perineal laxity

and incontinence in postpartum. This led them to express that their perineum was, in fact, not as intact as diagnosed.

The term pain should, therefore, be reconsidered following this research. Indeed, many participants began the interview by stating that they did not experience any pain, before going on to tell me that it only lasted for a number of day (up to 10 days) and explaining different kinds of perineal discomforts that influenced their postnatal experience. Moreover, if pain did not impact their movements, which was the case for most women in this sample, then it was referred to as 'discomfort', 'uneasiness', as opposed to pain. One person was also reluctant to use the word pain relating to childbirth as the positive nature of the event enabled her to welcome the pain, as opposed to any adverse event (injury, accident, illness) that might cause *pain 'No, it's more like a disturbance, let's say it goes with birth, like contractions, like the baby come, like the pain when you breastfeed, it's the same thing. I don't view it like pain or something that… that prevents me… like it's not like pain due to an accident, it's something normal'* (Jessica, interview 1) . Another aspect regarding pain was that the participants who described not experiencing any pain did not consider it an asset: *'Maybe it would have been better to experience pain'* (Sandrine, interview 1-). On the contrary, they felt that their perineum was inexistent and disconnected from their body, and unable to fulfil its role in sustaining the body: '*It was like a weight that I did not experience for my firstborn. It did not hurt, but it was uncomfortable and a little scary'* (Louisa, intervew 1). These feelings seemed to raise more fear and questions than the experience of pain by the other participants.

While the previous two subthemes referred to the nature of postpartum perineal sensations, the sub-theme 'not that limiting' explored the effects of these through an analysis of their timing. Participants explained that in their view, pain was understood as something limiting everyday life movements and activities, which was not what they experienced: '*For me pain is something that limits your actions or something that is more permanent. And limiting, that prevents movements you see'* (Delphine). The movements that caused pain, such as standing up/sitting down, urinating, showering,

defecating, were actions that were limited in time and the sensations were, therefore, expected and better dealt with through small adaptations of these actions: *'At first for a couple of days I had haemorrhoids which is not good but it did not hurt, I just had to be more careful when wiping'* (Sandrine). Urinating under the shower or sitting down carefully were some of the adopted strategies to limit the pain: *'During a week I had to urinate in the shower because otherwise it burnt'* (Julie).

The last sub-theme is called 'didn't have time to call it pain', and reveals how women in postpartum were occupied by other concerns that prevented them from managing to a put a word on these sensations that they did not want to call pain: *'Well in truth I did not experience much pain so my life took over and with the other children you don't pay much attention to yourself'* (Jessica). This subtheme shows that perineal pain is a small part of an overall experience that goes beyond that pain, which limits the focus that is given to it by women. This again may have been influenced by the high proportion of multiparous women in the participants and thus of women being busy with other children than the newborn. However, this begins to uncover that the birth experience must be considered as a whole and that the overall experience is of importance in explaining the little details.

Reassurance in normality

The second theme 'Reassurance in normality' explains the main determinant that helped participants make sense of their perineal pain. None of the participants mentioned levels of pain or pain relief as a determinant of postpartum perineal pain. This suggests that the reaction and attitude towards pain is more important than the pain itself. Being reassured meant the women were allowed to put this concern aside and not worry about it, which improved their experience. This was the case of Jessica: *'If you are prepared and know that you will experience some painful sensations, you are not worried when they come, not surprised'*. The participants explained achieving this using several elements to ensure the normality of their situation, all of which constitute sub-themes of the theme: Pleasantly surprised, Logical consequence of birth, Comparison with others, Using knowledge and connection with body, knowing it will hurt, but not how.

One of the first strategies was to over-prepare for excruciating pain, and, therefore, be 'Pleasantly surprised' by the outcome: *'I expected some difficulties, not being able to sit. And I could walk straight away when I had friends who could not sit and had many stitches and really complicated so I had readied myself for that… for the worse. So not having any stitches well yes I was pleasantly surprised and I had a good experience'* (Emily). Being able to explain the pain, describe the anatomic process that has caused it, was considered helpful in understanding that this was 'A logical consequence of birth'**.** While this reassurance and explanation may come from health professionals, the participants mentioned that they, in truth, knew within themselves that what they felt was a logical consequence of delivery: *'Well of course it's normal, a woman who tells me she did not feel any pain, I would say she is supernatural, not human. The head goes through the vagina so obviously the body changes'* (Sandrine). Using 'Comparison with others' was also frequently described, whether it be comparison with other people, friends and relatives, or comparison with previous experiences of birth, as might be expected from women who have already given birth. This led participants to consider themselves lucky, having a positive view of their pain and, therefore, an easier experience. Some participants also explained 'Using knowledge and connection with body' as a tool to improve their experience by building on confidence that their body was capable of going through this pain. This was described by Jessica who clearly explains how she built her confidence throughout her three birthing experiences: *'You can worry but when you expect pain to happen you welcome it, you do not undergo it passively'*. Emily, who has not prepared much for birth builds on her own inner confidence, based on her mothers' experience and the belief that she is genetically capable of overcoming whatever is ahead: *'My mother never had stitches so maybe subconsciously I took the same path: my waters broke without contractions, and I gave birth to a 4000g baby with no stitches. I was told I was destined to birth children. I was born under a good star'* (Emily)

The last sub-theme is different from the others as it describes a negative determinant 'Knowing it will hurt but not how'. This subtheme explains that while pain was expected and considered an unavoidable element of childbirth, preparing for something so prone to individual experience and

unprecedented was a challenge. Even second time mothers acknowledged that while they had experienced birth before, they were never sure their experience would be the same. This was the case for Charlotte for example, who has had four children, and was more disturbed because she knew not to expect anything specific: *'For the fourth it was painful, I felt it, and well, it wasn't like anything I had experienced before'*. Some women expressed that antenatal preparation was limited for postpartum and this was a problem, most of them acknowledged that preparing for the unknown was what they needed to know, and went back to referring to connection with body and self confidence as the best way to deal with postpartum perineal pain.

Managing the unexpected

The last theme that emerged from this study ties the experience of postpartum perineal pain to the overall experience of childbirth. This theme is entitled 'Managing the unexpected', and it includes subthemes that relate to both postpartum and birth itself. The subthemes 'Undergoing delivery' and 'Control of the events of birth' both describe in opposed perspectives how the sense of empowerment during birth influenced all steps of the experience. Some participants described 'Undergoing delivery', and described perineal sensations negatively in association with that. The main determinants that led to that feeling were the lack of choice in birth position, and going through induction. All participants who described feeling coerced in these aspects linked it with feelings in the perineum.

However, two participants explained that the events themselves were not the issue but rather the way they were brought about, without dialogue or consent from the woman. This is particularly well illustrated by the comparison of two participants, Jessica and Julie, both second-time mothers. Jessica reported that for her first birth she had had an epidural and did not have one for this birth and appreciated the second experience better *'I was able to become an actress of my delivery and live it fully'*. Conversely, Julie had the opposite scenario and preferred the birth with an epidural as this enabled her to have ownership of what was going on: *'I have a haematoma because she was stuck in*

the vagina because I was not in the appropriate position, so at one point, she took my legs and put them together. She aid I have to do this because she is stucj and well, she is not well […] I had a foot up and the one against the wall it was like.. it was like being at home… (Julie, interview 1). What these two participants mentioned in common was not the scenario itself, but the fact that they had a more positive experience in the case where this scenario was presented to them as a choice and where they felt fully empowered.

From that perspective, communication with the midwives during the process of labour and especially around decision-making during labour was cited as an important determinant of a positive postpartum experience. Delphine describes her feelings for her second birth *'This time, I felt ownership of my delivery. There were a lot more explanations, listening, exchanges. This makes a major difference'*. Conversely, being able to feel in control of the events of birth enhanced confidence and contributed to better acceptance and tolerance of postpartum pain. This was confirmed by many participants. Charlotte, for example who just had given birth to her 4th child, describes her 3rd delivery as 'the perfect delivery': *'Everything was working together towards the birth of the baby, the perineum being a part of the team'*.

These two subthemes explain the relationship between birth and postpartum perineal pain. Two other subthemes were identified as enhancing the experience of 'Managing the unexpected', which are linked to postpartum itself: Adjusting to a new kind of normal, Feeling overwhelmed by the event. These two subthemes point out how postpartum pain cannot be delt with as an isolated symptom but as a part of the overall experience. These subthemes both illustrate the intensity of the event of the birth of a child, and suggest that the challenges associated with this are at the core of the postpartum experience, thus leaving pain to be considered a small detail in comparison with the life-changing event that is the transition into parenthood.

The last subtheme 'Leaning on a positive state of mind' illustrates how participants described using their inner resources, optimism, and confidence to indeed 'Manage the unexpected'. *'We have*

been through delivery so in a woman's life it's like winning a victory, we managed, yes, we trusted our body and we are proud of what we experienced' (Jessica, interview 1). This theme provides an insight of how inner resources are the main elements that will help women deal with postpartum, given the uncertainty of the scenarios that will unfold. Focusing on the positive elements of their story was particularly helpful. This may also have been influenced by the fact that all of these women had straightforward births and their babies were in good health. This theme also emerged in the second interviews during the covid-19 lockdown where the participants built on the presence of their partners and the possibility for them to benefit from additional time off work which they felt was useful in their recovery, and influenced their experience of perineal sensations.

Reflective step- As I analysed the first round of interviews, I already noted that my preunderstandings were constantly changing, and that, with a concern for rigour, this needed to be documented. For that reason, I continued to write my understandings along the way in the form of a journal and conducted a systematic reflection of how the interviews shaped my views of the topic. Quickly, I noticed that my preunderstandings of what the determinants of perineal pain were postpartum may have seemed unusual and innovative because they did not relate directly to anatomic injuries, suturing or quantifiable elements and took account of the emotional aspect of pain. However, most of these determinants relate to external factors. The interviews began to reveal that the determinants of postnatal perineal pain are related to the overall experience of birth and are strongly influenced by inner perceptions of each woman on the way that things happened for them. For example, one of the major elements that influenced their experience seems to be their empowerment over labour, regardless of the scenario itself. This is in contradiction with my pre-understandings which identified a specific scenario (long labour, weight of the baby, duration of pushing…) that might lead to higher levels of pain. My ideas remained practitioner-centred ideas and this confirms the necessity to truly embrace a patient-led model of care and be open to this in my data analysis and further interviews.

Discussion

The three core themes- can't honestly call it pain, reassurance in normality, managing the unexpected - that were identified and contribute to the knowledge and understanding of postnatal perineal pain, add more widely to the understanding of experiences of birth and postpartum. The first theme, can't honestly call it pain, explains how perineal pain can only partly be compared to other types of pain. Therefore, there is a possibility that managing perineal sensations similarly to other types of pain is not adapted.

Reassurance in normality is a major theme in this study, as participants discuss how they achieve this reassurance by inner knowledge and resources, and outside help and information. Through the theme of expectations of pain, the findings of our study echo Way's (2012) qualitative study regarding women's experience of their perineum. Expectations occurs within themes in both studies, however the theme of 'return to normality' does not appear in this study while it is mentioned by Way (2012). This study findings focus more on the normality and expectation that postpartum pain will be a transitional stage that should not be worrying. While initially the timing of data collection was an explanation for this difference, conducting the second interviews around 6 months postnatally confirmed reassurance in normality as important. Most participants argued that although it is assumed by professionals that a period of 6 to 8 weeks is necessary before the body returns to normality postnatally, this was not their experience they had a longer transition. Soriano-Vidal et al (2018) have published how expectations can be shaped by prenatal education classes, which provides a means to act preventatively to address this issue for first time mothers, as the sample of participants was mostly second time mothers who had come to that knowledge and understanding through prior experience.

The third theme 'Managing the unexpected' in relation to the experience of pain is a new theme that is revealed by this study. The topic of empowerment over birth has been explored in other

research studies (Thompson and Miller 2014), however, the relationship between birth experience and the experience of postpartum pain has not been explored. Nevertheless, the literature relating to pain in some post-traumatic stress disorders suggests there is a link between experience and sensation (Outcalt et al 2014). This has been confirmed by Henne (2015) who studied the relationship between physical trauma and emotions. Ayers et al (2016) also writes about how the effects of a traumatic birth might be comparable to PTSD in other contexts, thus making the literature from that area relevant to this study. Therefore, this possibility that the overall experience of birth, and more specifically women's empowerment over birth, may be a way to improve all aspects of postpartum including perineal pain. From that perspective, midwives have a crucial role which the literature around emotional pain (Henne et al 2015, Dahlke et al 2017) and empathy (Hooker 2015, Smythe et al 2014) corroborates. This is also in line with current demands from women to be part of decision-making around their health and delivery, any other way of caring being considered 'obstetric violence' (Benyamini et al 2017).

Despite the insights that these findings provide, there are some limitations to the findings, specifically in relation to the time frame and the population. This study aimed to understand the determinants of postnatal perineal pain in the case of a perineum diagnosed as intact. The second interviews, took place when some elements were cancelled due to Covid-19 lockdown, such as the perineal rehabilitation sessions, and resuming work, which may have altered the women's experiences, reducing the applicability of the findings. Another limitation is the narrow population studied - 11 participants having given birth in two maternity hospitals. While the number of participants is recognised as being sufficient in providing rich data in qualitative research (Sandelowski 1995), the population is not varied in terms of origins.

This study also raised issues that were not the topic of interest but are worthy of further research and discussion. First, the concept of intact perineum was questioned at different stages of the research. When recruiting participants within the maternity wards, the perineal status of women

was first defined using the delivery records which mentioned it using the following: episiotomy, tear, lacerations, intact perineum. Women were visited in their room to confirm this in person before recruiting them. Some midwives documented women with an 'intact perineum' when there were lacerations that had not been sutured. If women are considered to have intact perineum, this might affect their care, and it would then be important to be aware that some women classified in that group might have lesions. Moreover, the sample of participants included women presenting with oedema, haemorrhoids, weak perinea causing incontinence, all of which are indeed anatomic lesions of the perineum, but are not always identified as such. Moreover, women with symptoms, such as these could still be described as having an 'intact perineum'. Again, this is practitioner-centered perspective that defines the perineal status according to what is required from the practitioner (i.e. suturing in that case). This is a simplistic vision and prevents midwives and other perinatal practitioners from taking a person-centred approach.

Conclusion

The aim of this paper was to provide an account of the determinants of perineal pain when the perineum is diagnosed as intact. This was undertaken using a Gadamerian research study design to collect data in a population of women having given birth in two maternities of the French region of Vaucluse in September and October 2019. The three themes identified - Can't honestly call it pain, Reassurance in normality, Managing the unexpected - give suggestions of recommendations for practice in the field of midwifery. Indeed, midwives should be aware of the effects an empowered birth experience,have on postpartum. They should communicate carefully around decision making and ensure that women's views are considered perinatally. Antenatally, parentcraft classes should encompass information about postpartum and give women tools to identify the medical normality of their situation. Postnatally, practitioners should be aware that women should be asked about their

perineum, regardless of the status documented, since this is not something that is standardised in medical practice in the French context.

Hooker (2015) emphasized the important role of active listening of practitioners in addressing a sensitive topic such as postnatal perineal pain. This is only achievable by getting better knowledge and enhancing understanding of practitioners of these issues. This study is a contribution to providing a more subtle, in-depth and precise understanding of a topic that has many impacts on health for mother and child. Further research in a larger timespan postpartum would add to this knowledge. A better understanding of the definition of postpartum pain and an intact perineum would be beneficial to have a more thorough understanding what women experience. Moreover, quantitative research regarding some of the factors raised by this study such as induction and its effects on the perineum in postpartum would be interesting to carry out.

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