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COMMENTARY

The postpartum silence

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Childbirth is arguably one of the most remarkable and transformative experiences a woman can go through. With it come many contradictions and uncertainties—the irreplicable joy of meeting a new baby of your own goes hand in hand with a loss of control and the impossibility of eliminating all associated risks. And when it comes to risks, pelvic floor injury that can lead to prolapse and incontinence is one that has historically been given less attention than it deserves.

Most pregnant women know little about the pelvic floor—what it is, how it is intimately related to and impacted by birth, or how potential injuries can shape the postpartum period. Such injuries can have consequences that most women are both unaware of and unprepared for.[1] And, when they occur, the feeling of being caught off guard can make recovery in the first months after giving birth harder to bear. For example, the athletic woman who gets joy from running or sports rarely considers that birth-related pelvic floor injuries may hinder her ability to continue these activities. So, is it not time and ethically necessary to openly discuss the risks of pelvic floor injury with women during prenatal care and to develop balanced ways of providing education?

Female pelvic floor disorders are and have always been common, and vaginal birth is a primary cause. Pelvic organ prolapse and treatments aimed at resolving the issue are described in Egyptian papyri dating back more than 3500 years. In the modern-day USA, 1 in 6 women has urinary incontinence, 1 in 30 has symptomatic pelvic organ prolapse, and 1 in 10 has faecal incontinence.[2] Despite these conditions being considered common through a statistical lens, most women only become aware of them if and when they happen to experience one. Not knowing how common their condition is, they often feel lonely, isolated and ashamed. This is particularly true in the postpartum period, and it is disheartening to see a sense of shame and failure overshadow childbirth and parenthood when, in fact, they should inspire awe and respect.

Not acknowledging the frequency with which pelvic floor dysfunctions occur is fundamental to these issues becoming stigmatised. This is pointedly illustrated by the 'prevalence paradox' described by Kumar et al.: The mutually reinforcing cycle of silence between patients and healthcare providers makes it challenging to know the true prevalence and, therefore, perpetuates the notion that women who do experience it are deviant from the norm.[3] Stigma—in pelvic floor health as much as in any other topic—is not built by any one thing; rather, it is composed of a broad and complex network of factors. However, if not the sole culprit, this self-sustaining cycle of silence is a great contributor to the sense of shame and stigma surrounding pelvic floor problems. The woman who is out to dinner with friends and has an incontinence episode, or the woman who discovers while showering that a mass is coming out of her vagina, has rarely heard similar stories that she could relate to. When not openly acknowledging these issues, we as healthcare providers are unintentionally harming women by perpetuating silent struggles.

What makes for a 'good birth' is deeply personal, multidimensional and not restricted to the hours during labour. Nor does it have a straight link to mode of delivery. The current and narrow concept of successful birth—vaginal delivery of a healthy baby—potentially invalidates many women's different but equally gratifying birth experiences and leaves little room for pelvic floor issues to be discussed postpartum. If having a vaginal birth is the ultimate valued goal, anything that occurs after that, will struggle to surface as worthy of attention.

Part of the unintended secrecy around postpartum issues comes from the long-standing debate between trusting the natural birth process (often ascribed to midwives) and a more intervention-based approach to birth (often ascribed to physicians). This unfortunate and contrived dichotomy, aside from failing to put what truly matters to women at the centre, often leaves healthcare providers with the concern that focusing on potential postpartum issues promotes the

interventionalist side of the coin and encourages caesarean delivery to spare the pelvic floor. Birth, as becomes clear to anyone who takes a step back and looks at this debate from the outside, is much more complex than how this dichotomous view frames it and is certainly not an *either/or* matter. The female body is capable of the remarkable phenomenon of childbirth *and* is also intrinsically vulnerable to changes in pelvic floor function that we call birth injuries—one neither negates nor overrules the other. Bringing this duality to light could be an entry point to discussion and the base for developing honest, thoughtful and sensitive ways of educating women on pelvic floor health.

When considering prenatal education about pelvic floor disorders, providers fear unnecessarily scaring women, as injuries often cannot be reliably predicted or prevented. Instead, we tend to adhere to the concept that we are better off addressing problems when they occur. However, this lack of informed consent would not be tolerated in other areas of medicine. For instance, it would be unethical not to inform women undergoing hysterectomy of the possibility of ureteral injury despite the incidence being less than 1%.[4] In comparison, the incidence of major levator ani muscle injury with spontaneous vaginal birth is over 15% and, with forceps use, it increases to 50%.[5] Women should not learn about pelvic floor disorders and the birth factors that contribute to their occurrence only once symptoms arise. They should not need to resort to Googling symptoms to learn what has happened to their body. While knowledge of childbirth-related pelvic floor injuries will likely not change the outcome, having information may put them in a better place to process these consequences should they occur.

The concern that risk counselling can potentially create undue fear is a valid point. More information is not always better, and data without context can be overwhelming to process. Thus, figuring out what information is helpful and what is potentially harmful, is challenging but critical. Progress is made through deliberate practice—tailoring a way of delivering this message is something we healthcare providers should exercise, polish and perfect. Only the woman herself can give the final verdict on whether information is helpful or harmful, based on the knowledge of her own body, her own values and her own expectations. As healthcare providers, we should be prepared to provide women with the information they may want, be ready to accept that some women prefer not to have all the details and, most importantly, avoid deciding that our patients do not need this information based on our own perceptions.

When working with women who have experienced birth injuries, you often hear 'why did no one tell me this could happen?'—a question that expresses a woman's sense of being blindsided, as well as feeling betrayed by the lack of information. However, it could also be said that women who experience uneventful births would prefer not having gone through the stress of knowing possible unfavourable outcomes. The tricky part is that we do not know beforehand what each individual woman's outcome is going to be. Although we have have made progress in research, we still do a poor job at predicting birth injuries.[6] Counselling on risks and consequences well before potential interventions that impact the pelvic floor, such as forceps delivery, occur in labour allows us to truly partner with women in decision-making.

Often, the greatest source of distress for women with postpartum issues is not the pelvic floor symptoms themselves, which are usually manageable or resolve with postpartum recovery—rather, it is the isolation, the shame, the feeling that they have been betrayed by their own bodies, or even the feeling of having been patronised. And if birth injuries are not always preventable, misinformation is.

We need to talk about postpartum pelvic floor problems—these women's stories should not be a surprise to anyone. We need to talk, and then talk some more, until stigma and shame fade; until we move to the point where birth injuries are treated more like sports injuries, that need care, rehabilitation and preventive programs—not like horrifying, shameful events to be hidden from view.

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CONFLICT OF INTERESTS

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