

CLINICAL PAPER

A qualitative study exploring the lived experience of having anal incontinence in the early postnatal period

S. Colebrook Hutchens

First Community Health & Care CIC, Physiotherapy Department, East Surrey Hospital, Redhill, UK

P. Vuoskoski

School of Health Sciences, University of Brighton, Brighton, UK

Abstract

Anal incontinence is a possible consequence of childbirth, and it has been shown to have a significant impact on women's quality of life. However, little work has been published about the experience of anal incontinence from the perspective of qualitative research. A phenomenological (qualitative) enquiry can provide invaluable insights and a deeper understanding of the lived experience and implications of anal incontinence. Two qualitative studies have previously explored the experience of anal incontinence following a vaginal delivery. Both investigations recruited women in the 26–56-year-old age range, which indicates that, for some of the women involved, the delivery of their baby had been some years prior to the interview. The present phenomenological study focused on the early (< 12 months) postnatal anal incontinence experience. Three participants were purposefully recruited to take part in face-to-face, open-ended interviews, which were recorded and transcribed verbatim. The transcripts were then analysed on the basis of the descriptive phenomenological method developed by Amedeo Giorgi. The phenomenological descriptive analysis revealed that the essential structure of the participants' early postnatal anal incontinence experience consisted of six key elements that all have significant empirical implications: the changed body; the evolving sense of self; a sense of becoming familiar; a sense of hope; emotional engagement; and an overriding sense of putting the baby first. It is hoped that these results will: add to the qualitative, meaningful evidence base in the field; help to understand how the phenomenon is experienced by women; direct further qualitative research; and perhaps, contribute to the development of therapeutic services and empathetic care for these women.

Keywords: anal incontinence, lived experience, phenomenological descriptive analysis, postnatal period, qualitative study.

Introduction

A potential consequence of childbirth (Sultan *et al.* 1996), anal incontinence has been defined by the Royal College of Obstetricians and Gynaecologists as “any involuntary loss of faeces, flatus or urge incontinence that is adversely affecting a woman's quality of life [QoL]” (RCOG 2007, p. 1). The incidence of postnatal anal incontinence has been reported to be 39% at 6 months (Rikard-Bell *et al.* 2014),

32% at 10 years (Nordenstam *et al.* 2009) and 47% at 20 years (Gyhagen *et al.* 2014), and flatal incontinence has been identified as the most prevalent symptom of the condition (Laine *et al.* 2011). Many studies have linked the development of postnatal anal incontinence to third- and fourth-degree perineal tears sustained during delivery (De Leeuw *et al.* 2001; Borello-France *et al.* 2006; Mous *et al.* 2007; Badiou *et al.* 2010; Bols *et al.* 2010). In addition, the use of forceps during a primiparous delivery has been found to have a strong association with persistent faecal incontinence (FI) (MacArthur *et al.* 2005).

Correspondence: Sharon Colebrook Hutchens, First Community Health & Care CIC, Physiotherapy Department, East Surrey Hospital, Canada Avenue, Redhill RH1 5RH, UK (e-mail: Sharon.hutchens@nhs.net).

There is some evidence to suggest that the true incidence of obstetric anal sphincter injuries (OASIS) may be underreported. With the use of endoanal ultrasound, it has been demonstrated that women without a clinically recognizable third- or fourth-degree tear may still sustain anal sphincter damage, and that forceps delivery is significantly associated with these injuries (Sultan *et al.* 1993; Guzmán Rojas 2013). However, anal incontinence is not a symptom exclusive to women who have experienced perineal trauma, or even women who have had a vaginal delivery, as demonstrated by Guise *et al.* (2009). These authors found that 37.7% of women who had had a Caesarean section without initial labour or pushing reported some symptoms of postnatal anal incontinence. In addition, a recent study found that the main predictor of having anal incontinence at one year after birth was the development of this condition in the late stages of pregnancy, rather than the type of delivery (Johannessen *et al.* 2014a).

Poor physical health in the postpartum period, including FI, has been associated with poor mental health and postnatal depression (Brown & Lumley 2000; Woolhouse *et al.* 2014), and several studies in different contexts have shown that the condition has a significant impact on QoL scores (Handa *et al.* 2007; Bartlett *et al.* 2009). However, following delivery, very few women seek help for anal incontinence in the early postnatal period (Brown *et al.* 2015), and Samarasekera *et al.* (2008) found that only 29% of women who still had anal incontinence 10 years after delivery had sought advice or treatment for their problem. It has been suggested that patients' QoL reduces over time if they fail to seek treatment (Bartlett *et al.* 2009).

The value of the existing quantitative research is generally acknowledged in the field. Nevertheless, Birch *et al.* (2006) suggested that qualitative enquiries may provide a greater depth of understanding of the "true impact" of anal incontinence to an individual's health and well-being. In the present authors' view, phenomenological research in particular can provide invaluable insights into the qualitatively significant meanings and implications of anal incontinence, as lived and experienced by individual women. Previous qualitative studies have suggested that anal incontinence may encompass physical, emotional, social and psychological problems (Collings & Norton 2004; Wilson 2007; Peden-McAlpine *et al.* 2008). However, these studies did not specifically involve postnatal women

who had developed anal incontinence following childbirth.

Only two previous qualitative studies were found by a literature search that explored the experience of anal incontinence following a vaginal delivery. Rasmussen & Ringsberg (2010) completed their study in Denmark using a grounded theory approach, and Tucker *et al.* (2014) conducted their study in Australia based on an interpretive phenomenological method. Although the findings of these studies are qualitatively significant, Denmark and Australia have different healthcare systems to the UK, and therefore, are not fully comparable. In addition, both studies recruited women in the age ranges of 26–56 and 28–50 years, and did not indicate when the women had given birth.

The participants' age range in the previous studies (Rasmussen & Ringsberg 2010; Tucker *et al.* 2014) suggests that, for some of these women, the delivery of their baby may have taken place a number of years prior to the interview, and neither study discussed any experience of looking after a baby while simultaneously suffering from anal incontinence.

Furthermore, Lo *et al.* (2010) reported that 18.5% of women with postnatal anal incontinence had declared that the problem had affected their child-rearing abilities. The same authors also identified the early postpartum period as an important time for bonding with the baby, and postnatal anal incontinence may have consequences for both maternal and child health. Therefore, it may be important to explore the experience of having anal incontinence in the early postnatal period more closely.

The aim of the present study was to contribute to phenomenological empirical knowledge in the field of physiotherapy about the phenomenon of early (< 12 months) postnatal anal incontinence. Phenomenology as a research methodology has its origins in the philosophy of Edmund Husserl (1859–1938). In the Husserlian sense, the aim of phenomenology is to describe and clarify the meaning of a phenomenon as it is lived and experienced, and to describe its essence or essential (meaning) structures (Giorgi 2009). After describing the essential structure, an existential (interpretive) phenomenological approach was applied, and the taboo nature of the subject was highlighted in the form of a poem (Colebrook Hutchens & Vuoskoski 2017). However, the present paper focuses on the descriptive phenomenological findings of the present study.

Participants and methods

Ethical approval for the present study was obtained by the Faculty of Health and Social Science, Science and Engineering Research Ethics and Governance Committee at the University of Brighton. The inclusion criteria required the participants to be women who had experienced anal incontinence following a vaginal delivery, and who were still less than 12 months postnatal, regardless of the frequency or resolution of their symptoms. Women who were more than 12 months postnatal, had suffered a stillbirth or neonatal death following delivery, or had a medical condition that could explain the anal incontinence (e.g. Crohn's disease) were excluded from the study.

Three participants who matched the inclusion criteria volunteered for the study. They were recruited locally from NCT (National Childbirth Trust) branches, a Sure Start centre and two postnatal exercise groups (see Table 1 for their characteristics). After volunteering, each participant was invited to an individual, face-to-face interview that was conducted by the first author (S.C.H.). This began with a single, open question: "Can you tell me about a specific experience of anal incontinence that you have had since having your baby, in as much detail as you feel comfortable?" No further structured questions were asked, but prompt questions were prepared, such as: "Can you tell me more about that?" or "Can you tell me about the first time it happened?" These enabled the interviewer to get additional description without using leading questions. All participant interviews were audio-recorded and transcribed verbatim for further analysis.

Data analysis

The three participant transcripts were analysed using Giorgi's (2009) descriptive phenomenological method. Initially, the researcher interviewer (S.C.H.) read the transcripts several times in order to become familiar with the full description and global sense of the data. While reading and analysing the information, she adopted

a phenomenological descriptive attitude and a physiotherapy disciplinary perspective, while being sensitive with regard to the phenomenon, i.e. early postnatal anal incontinence as a lived experience.

The first step of the analysis, as described by Giorgi (2009), was to break down the whole transcript into units of meaning. In practice, a mark was made between these units each time a change in the meaning of the text under scrutiny was identified. With regard to phenomenological attitude and the first step of the method, Giorgi (1997) pointed out the need for a mindset open enough to allow unexpected meanings to be intuited, as opposed to specifying meanings to be searched for in advance. The researcher maintained this attitude throughout the analytic process.

The second step was to rewrite the units of meaning, keeping the everyday language of the participant, but rendering this in the third person. This was to highlight that the researcher was analysing another person's experience and not her own, reducing the tendency to identify/empathize with the experience of the other (Giorgi 2009).

The third step was to transform the units of meaning phrased in everyday language into expressions that more explicitly revealed the disciplinary insights or implications that each unit was carrying for the lived phenomenon. This required the researcher to dwell on the data, to change it and vary it imaginatively on the basis of specific (signifying–fulfilling–identifying) conscious acts (see Giorgi 2009, pp. 130–137). In practice, this required several versions to be written before formulating the desired expression that described the most invariant sense of each meaning unit. At the end of the third step, a summary of the transformed units of meaning (i.e. a condensed description of every unit identified) was written for each participant.

The final step of the analysis was to articulate the essential (i.e. unifying) structure of the lived experience of early postnatal anal incontinence, as described by the participants in the present study. This was achieved by carefully

Table 1. Participant characteristics

Participant	Variable			
	Parity	Postnatal period	Type of delivery	Type of incontinence
P1	Primiparous	8 weeks	Forceps-assisted delivery with episiotomy	Flatal incontinence, faecal urgency
P2	Primiparous	11 months	Unassisted vaginal delivery with no perineal trauma	Faecal incontinence, flatal incontinence, faecal urgency
P3	Primiparous	5 months	Unassisted vaginal delivery with third-degree tear	Flatal incontinence

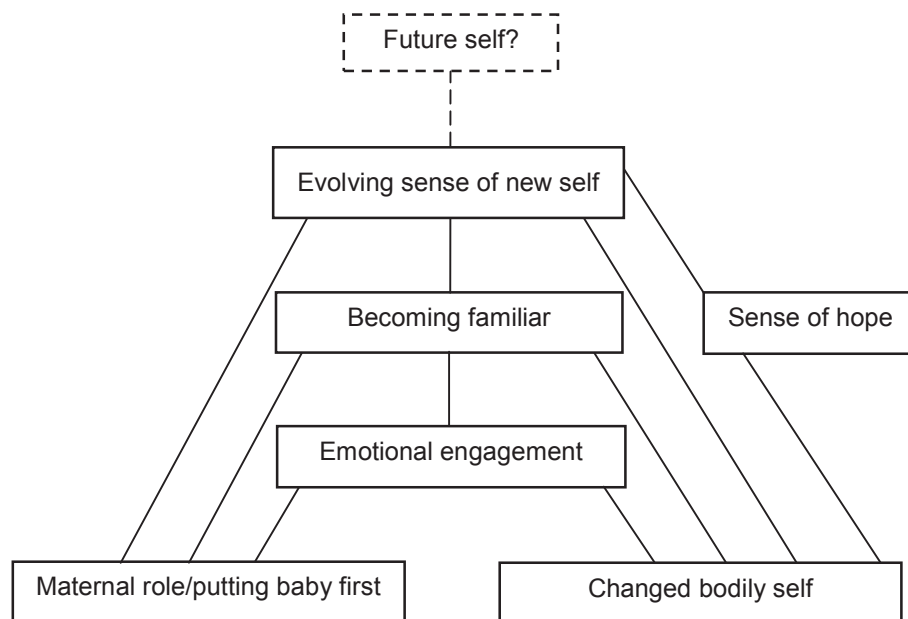


Figure 1. Visual representation of the key constituents, and the relationship of these units of meaning within the essential structure of early postnatal anal incontinence.

examining all of the last-transformed units of meaning for each participant, and looking for unity. As pointed out by Giorgi (2009, p. 166), this unity is rarely a single idea: “[T]he structure usually consists of several key constituent meanings and the relationship among the meanings is the structure.” In practice, researchers employing the phenomenological descriptive method seek a unity of identification that synthesizes the various experiential profiles of the phenomenon; as long as the profiles synthesize harmoniously and coherently, a more-integrated presentation of the phenomenon can be perceived. It was this sense of the whole that guided the integrated synthesis, and described the essential structure and its key constituent meanings.

Hence, by reading and rereading the participant summaries, the researcher (S.C.H.) intuited the most invariant meanings (i.e. the key constituents) based on imaginative variation, and the specific conscious acts, while operating within the phenomenological reduction, and being sensitive to the phenomenon and the chosen disciplinary perspective. As a result, the essential structure, which consisted of six key constituents, was finally articulated. A diagrammatic form of the structure was also produced in order to show the relationship between the key constituents within the structure (see Fig. 1).

All steps of the data collection and analysis were carried out by the first author (S.C.H.) while she was undertaking her Master’s degree in clinical research in collaboration with the second author (P.V.), who was her research supervisor.

Results

The main result of the phenomenological descriptive analysis process is the essential structure of the lived phenomenon (Giorgi 2009). This is the reduction of all the raw data from the three participants into a single paragraph. It contains the most invariant meanings that are present within the lived phenomenon, and therefore, that must be present within each individual participant’s experience. The essential structure presented below is comprised of six key constituents (i.e. the invariant meanings), and these include: the changed bodily self; a sense of becoming familiar with the postnatal body; emotional engagement; the maternal instinct of putting the baby first; a sense of hope; and an evolving sense of self. Figure 1 shows the inter-relatedness of the key constituents in diagrammatic form. The complete essential structure of early postnatal anal incontinence that resulted from the analysis is shown in Box 1.

Discussion

The changed bodily experience

All three participants described changes in their bodily selves that stood out from their anticipation about and overall experience of having a child, and the resemblance of their assumptions and the actuality. They all described significant moments of not being able to fully sense and/or control their bowel function that they felt interfered with their life as a mother, partner and friend. These experiences resonate with the

Box 1. The essential structure of early postnatal anal incontinence from a human science and physiotherapy perspective

The participants' experience of early postnatal anal incontinence involves coming to terms with a body that has changed in an unexpected way that, at times, cannot be controlled or predicted. This interferes with their new role as a mother, and established roles with others (e.g. as a partner and friend). These changes encompass significant emotional engagement. The participants are anxious about their uncertainty about their body, how they might manage it and how it may influence their future. Their symptoms can evoke embarrassment, or fear of embarrassment, particularly in public situations, and there can be a reluctance to disclose the problem to others. The participants have an overriding instinct to put the needs of the baby first, regardless of the consequences for themselves. The women begin to develop familiarity with their new body and the role of motherhood, and are, more or less, hopeful about the possibility of recovery.

ideas of Galvin & Todres (2013). In their theory of well-being, these authors present the idea that "familiarity", including that of our bodily self, creates a sense of "being at home". From that perspective, the changes that the participants experienced in their bodily selves, i.e. the ability to sense and control their bowel function, may have significant implications at the empirical level, awakening a sense of "unfamiliarity" and "homelessness".

In the present study, the participants suggested that the symptoms of postnatal anal incontinence were "unexpected", and linked this with a lack of information. This finding also had significant implications for their lifeworld. The participants felt unsure about: whether the symptoms were "normal"; whether they had "caused" the symptoms themselves; what they could have done to help improve the symptoms; and whether there was any potential for the symptoms to resolve. Participant 2 (P2) stated that, although she had searched extensively on the Internet, she had found very little advice or information, which is in line with the first author's (S.C.H.'s) own experience. Very little information appears to be available online, and there is a lack of support groups for this specific group of women, which echoes previous findings. The lack of information about postnatal incontinence was also reported by Rasmussen & Ringsberg (2010), which reinforces the idea of postnatal anal incontinence being an "unrecognized" and "abnormal" condition that induces feelings of shame and marginalization. Hence, based on the findings of the present study and previous literature, it can be stated that there may be a need for further education on this topic and the provision of support groups for women with postnatal anal incontinence during both the antenatal and postnatal periods. Furthermore,

healthcare professionals also need to meet and treat these women.

All of the participants in the present study emphasized that the symptoms of anal incontinence interfered with their relationships with others. The findings strongly suggest that "knowledgeable others" should be able to support all women in similar situations. They should have opportunities to share their experiences and expose their vulnerabilities without feeling shamed or embarrassed. Being able to share personal experiences of FI with other women living with similar symptoms was found to be a great source of comfort in a previous study by Peden-McAlpine *et al.* (2008). As noted by these authors, it created an opportunity to share information, experiences and practical strategies to deal with the symptoms. Therefore, it would be reasonable to assume that an online forum specifically set up for postnatal women who have developed anal incontinence could be useful. This would be a way to inform these individuals about their condition. An online forum could also provide a support network that would allow women to discuss this topic relatively anonymously, and therefore, with a reduced sense of embarrassment.

All three participants in the present study had experienced flatal incontinence. They described this as occurring with "no warning", and reported that they had no control over it and that it was "always loud". The participants also indicated that it was a difficult symptom to cover up. In line with this, flatal incontinence has been reported to be the symptom of anal incontinence that causes the most embarrassment (Peden-McAlpine *et al.* 2008; Johannessen *et al.* 2014b). This finding was also reflected in the experience of participant 1 (P1):

“Bizarrely, it was always really loud . . . which was why it was embarrassing, and frankly, if it was silent, I might have just not bothered mentioning it to my husband, but you know, there’s no getting around it when it’s such a trumpeting sound.” (P1)

Participants 1 and 2 both described their experiences of faecal urgency, a symptom that may be considered to be less severe in comparison to FI. However, the following description given by P2 emphasizes that there can be a very fine line between faecal urgency and FI:

“There’s been numerous occasions where it’s absolutely urgent to get to the loo when I sort of run around and just make it. . . It’s already in the process of starting to . . . the bowels are already opening; it’s like, you know, just literally catching it into the toilet. . . It’s like the process is already starting, and I’m getting there by luck rather than my muscles being strong enough to keep everything intact before arriving, if that makes sense. . . It just . . . it literally feels like a battle that, you know, that my muscles aren’t winning, you know. . . It’s very urgent. . . It’s just immediate, sort of, you know, and it’s . . . things are half out already really, you know, I’ve only just managed not to get them on my clothes, and they’re, you know, on their way out as I’m sitting down on those more urgent times.” (P2)

Overall, the empirical findings of the present study address the unpredictability of the condition, as experienced by the participants. All three implied that their inability to control their bodily functions not only led to a fear of these symptoms, but also to worrying about ones that they had not yet experienced. Participant 1 described being frightened of having FI, and concluded that, if she could not hold in flatus, this could mean that she would not be able to hold in faeces either. For both P1 and P2, faecal urgency led to a fear of experiencing FI if they were unable to get to a toilet in time. All three participants described being frightened of having an accident in public. If the fear of a symptom such as FI leads to an alteration in behaviour (e.g. avoidance of social interaction), such a change may have the potential to be as significant as the symptom itself. This would suggest that any objective measurements used (e.g. frequency of symptoms) may not necessarily capture the true significance to and implications

of anal incontinence for the lifeworld of an individual.

The changed body also resonates with the experienced sexual self, as reflected by the present participants responses. For P1, the unknown potential of suffering from symptoms during sex related to increased feelings of anxiety and self-consciousness, limiting her enjoyment of intercourse. Participant 3 (P3) first experienced the symptoms during the first time she had sex after having her baby, which caused her embarrassment and anxiety because this was something that had never happened before. The fear of suffering from symptoms during sexual relations was also reported by Tucker *et al.* (2014), who stated that this resulted in women no longer seeing themselves as sexually attractive. Whereas all three participants in the present study had supportive partners, Rasmussen & Ringsberg (2010) reported that one of the concerns of single women with anal incontinence was that they would not be able to start new relationships. This was because they were worried about having symptoms and how a new partner may react. Together with the results of the present study, Rasmussen & Ringsberg’s (2010) findings again highlight the significance of ongoing support for these women from “knowledgeable others”. This allows them to share their experience, and in so doing, realize that they do not have to deal with their symptoms and concerns on their own.

Emotional engagement

There was a great deal of emotional engagement with the lived moments of anal incontinence, and discussing it with other people. Embarrassment and a fear of being embarrassed, especially in public, was an emotion that was strongly interrelated with the symptoms by all three of the present participants. In their experience, this embarrassment made them reluctant to talk to others about their symptoms, even healthcare professionals. When describing talking about their symptoms with their partners or close family, the participants indicated that the discussion was more or less unavoidable. This is demonstrated by the following quotation from the raw data:

“Yeah, a little bit embarrassed. To be honest, I didn’t feel the need to tell anyone; my husband sort of thought I was in the loo for a long time, so I ended up telling him what had happened, but he’s so down-to-earth that I didn’t feel ashamed to do that.” (P2)

The participants also mentioned that they did not go into all the details about their problem, and withheld some information, a finding that was also reported by Rasmussen & Ringsberg (2010).

The results of the present study suggest that women may not report their symptoms of anal incontinence to healthcare professionals. Although P2 and P3 both received treatment for the condition, they said that they initially sought help for a prolapse, and did not discuss their symptoms of anal incontinence at the initial consultation. A reluctance to initiate a discussion of anal incontinence with healthcare professionals was also reported by Tucker *et al.* (2014). However, when women do discuss the issue with healthcare professionals, if the response is inappropriate, or their situation is trivialized, they would then avoid reporting it again for many years (Peden-McAlpine *et al.* 2008). Rasmussen & Ringsberg (2010) reported that women felt neglected when their problems with anal incontinence were met with a lack of understanding by healthcare professionals.

The present participants reported that there were times when their lack of control over their bodily symptoms led them to feel ashamed, even if an accident had occurred in a private situation. In modern society, a great emphasis is given to gaining bowel control as a child, which is practically considered to be a rite of passage when growing up (Collings & Norton 2004). Therefore, a loss of bowel control as a healthy adult is not generally considered socially acceptable or normal. This is exemplified by P2's experience:

"I was a bit gutted, a bit shocked, but sort of thought, well, I couldn't help it . . . felt like I was five again, put my clothes in the wash, and you know, had a shower and sort of wiped everything clean again, and sort of just, yeah, you know, it wasn't very pleasant . . . yeah, a little bit embarrassed. . . It was a bit upsetting." (P2)

The present study strongly suggests that there are taboos about anal incontinence that need to be broken, and healthcare professionals may have an important role to play in this process. Women need to take part in open discussions of the possibility of these symptoms occurring both before and after birth. This is a task that all healthcare professionals could and should embrace, and once again, such discussions may help women who are experiencing the condition to feel less ashamed and embarrassed. However,

this requires further education and professional knowledge of how to manage these situations.

Maternal instinct: "baby comes first"

In the raw data, all three participants described situations when they put the needs of the baby before their own, despite the possible consequences to themselves. At the very least, they all tried not to let their symptoms interfere with the daily routine of looking after their child. For P2, this was shown when she acknowledged that it was important to her to complete the activity of caring for her baby before going to the toilet, and that this had once resulted in an episode of FI.

As indicated by the participants, when the bodily functions that they could not control did interfere with caring for their child, this created feelings of guilt. Participant 1 described feeling like "a terrible mother" for having to breastfeed in the toilet, which was a result of getting faecal urgency when her baby was crying for milk. She said that she initially could not leave the baby to cry and go to the toilet first, and then felt guilt for taking her baby with her to the toilet. The presence of such feelings is evident in the following partial description:

"Obviously, it's a bit harrowing when you've got this this baby just screaming like, *You terrible mother, you're not feeding me!* And so, yeah, and you do think this is not terribly hygienic. . . That is quite stressful really. . . You can't leave the baby downstairs there, screaming her head off, especially when she's tiny." (P2)

Previous studies have also discussed mothers' feelings of guilt, and the reluctance of women to put their own needs before those of their family (Tucker *et al.* 2014). However, the present study demonstrates the uniqueness of the early postnatal period, and the significance of the "maternal instinct" during a time dedicated to looking after a young baby who is dependent on the mother. It may be important for all healthcare professionals to acknowledge that women may be less likely to seek treatment, find it difficult to attend appointments and not adhere to treatment programmes. Linking services for the baby to those for maternal healthcare may give postnatal women a greater opportunity to seek advice and easier access to treatment. This may also ensure that postnatal women are aware of the available maternal services, and reduce the bias of healthcare towards the baby.

Both P1 and P3 described their experience of the healthcare system prioritizing the health and care needs of the baby above their own. For example, on her discharge from hospital, P1 described receiving lots of advice about where to go if there were problems with the baby, but feeling less confident about what to do if she experienced problems herself. She also mentioned how the postnatal check-up was automatically booked in for her baby, but it was her responsibility to book her own 6-week check-up with the general practitioner. Once again, these experiences may have encouraged these women to acknowledge that the needs of the baby had to be placed before their own, despite the possible consequences to themselves.

Sense of becoming familiar with the postnatal bodily self

The present participants implied that they had a positive sense of “becoming familiar” with their changed postnatal body, and learning how to manage the symptoms of anal incontinence. This sense of “becoming familiar” also resonates with the concept of “homecoming”, as described by Galvin & Todres (2013) in their theory of well-being. These authors described “homecoming” as an element of “being well”, one that contrasts with “homelessness”. According to this theory, by developing familiarity with their changed body, women should also develop a more-positive sense of well-being, regardless of the presence of symptoms. For the present participants, a sense of becoming more familiar with the bodily symptoms was very strongly interrelated with feelings of learning to manage the condition. For example, P1 described a strategy that she had developed with her husband after an incident of faecal urgency: if she said that she needed the toilet, her husband understood that it was urgent and quickly took the baby from her. After realizing that she had more flatus to deal with if she was constipated, P3 mentioned a strategy that she had developed that involved trying to manage her constipation by drinking plenty of fluid.

However, in previous studies, participants who had lived with their symptoms for a longer period developed less-positive strategies, including social avoidance, self-imposed isolation and a reduction in physical exercise (Peden-McAlpine *et al.* 2008; Rasmussen & Ringsberg 2010; Tucker *et al.* 2014). These did not appear in the present study. Since this was the early postnatal period, the participants may not have developed

these negative strategies. However, these may arise later. Therefore, the present results might suggest that a timely physiotherapy intervention could help women to develop helpful strategies for managing their symptoms, and increase the potential for well-being and/or early resolution. Once again, this may help to prevent the development of negative strategies that have adverse implications in the future.

Sense of hope

Based on the empirical data, the present study identified significant implications in relation to the early postnatal period. One of these is the presence of hope in all the participants’ descriptions. They suggested that they were hopeful about the possibility of recovery, and their bodies going through a healing process following the delivery. This sense of hope was strongly correlated with: the participant’s experience of the treatments available; the identification and confirmation of muscle weakness; and the development of a plan of action involving physical exercise. Similar findings have not been reported previously, and may be unique to the experience of early postnatal anal incontinence. However, further research would be required to understand these characteristics and their relationships in more depth.

Despite their overriding sense of hope, the present participants also described feelings of hopelessness that were related to: the persistence and/or plateauing of symptoms despite doing pelvic floor muscle exercises (PFMEs); uncertainty about whether they were performing the exercises correctly or regularly enough; and feelings of self-blame for not being more motivated to do the exercises, despite wanting to get better. Similar feelings of self-blame and inadequacy when treatment regimens failed were previously reported by Peden-McAlpine *et al.* (2008), with women commenting that they were not consistent or compliant enough with the exercises, or that their technique was not good enough. Therefore, the present study strongly suggests that these feelings need to be acknowledged by the therapeutic and care practices these women attend.

Healthcare professionals such as physiotherapists may be able to enhance the sense of hope that postnatal women have by providing information about the causes and treatment of postnatal anal incontinence. They can provide women with valuable feedback about the extent of any muscle weakness by performing objective vaginal and/or anorectal examinations, and help by teaching them

the correct technique for PFMEs. However, when devising an individual exercise programme, the physiotherapist must ensure that it is realistic and manageable for women to achieve. Hay-Smith *et al.* (2011) suggested that regular reviews involving continuous, professional encouragement may improve outcomes in women being treated for urinary incontinence. Therefore, these may also be beneficial for women with postnatal anal incontinence, and prevent them from developing negative feelings of self-blame and inadequacy.

The evolving sense of self

The participants in the present study were becoming familiar with their changed and changing postnatal body, and their new role of being a mother, and balancing these factors with their previous roles and responsibilities. Work life has previously been identified by Peden-McAlpine *et al.* (2008) as presenting the most complicated situation in which to deal with FI. This is because the condition has the potential to limit the ability of individuals to engage in productive work outside of their home environment. All three participants in the present study were still on maternity leave, and it is possible that they had not had to deal with this particular issue. However, P3 stated that she was concerned about returning to work in case she experienced her symptoms in front of her clients. Therefore, timely advice and meaningful treatment in the early postnatal period may maximize resolution, and the development of strategies that can enable a return to work.

Limitations

The findings of the present study should be considered in relation to its limitations. This was a context-limited study involving three participants, which is in line with the suggested requirements for a descriptive phenomenological study investigating the structure of a phenomenon, as opposed to the individualized experience of that phenomenon. As noted by Giorgi (2009), there should always be at least three participants in order to ensure sufficient variation in the raw data; however, in theory, the essential structure of a phenomenon could be articulated on the basis of a single, rich description of an experience. All three interviews in the present study yielded rich, concrete descriptions of the experience of early postnatal anal incontinence. However, it should be noted that all the participants came from a small

geographical area, and were receiving care from the same acute trust.

Strengths

The present study successfully captured a unique aspect of the experience of postnatal anal incontinence. By examining the early postnatal period, which is a time when contact with healthcare staff is high, new insights have been gained, allowing a deeper understanding of the phenomenon, and this may resonate with the experiences of healthcare professionals in similar contexts and inform their practice. The authors did not recruit through the National Health Service, and consequently, one participant was enrolled who had not sought help for her symptoms. Only one of the three participants had sustained a third-degree tear. This gave the authors an opportunity to explore diverse experiences of early postnatal anal incontinence.

Recommendations for further research

The present participants had all delivered healthy babies. Therefore, it may be important to further examine the experience of having postnatal anal incontinence when this is not the case (e.g. after a stillbirth, neonatal death, surrogacy or adoption). Such future research would provide a better understanding of the phenomenon in such a situation. The present participants discussed their experiences of receiving healthcare, but it would be useful to examine this area further. In particular, future research could focus on the experience of receiving specialist physiotherapy assessment and treatment, something that was discussed positively by the present participants.

Conclusion

Using a phenomenological descriptive approach, the present study explored the lived experience of early postnatal anal incontinence of women who had had a vaginal delivery. The essential structure based on the data consisted of six key constituents: the changed bodily experience; emotional engagement; the maternal instinct of “baby comes first”; becoming familiar with the postnatal bodily self; a sense of hope; and the evolving sense of a new self. Significant implications were identified on the basis of the evidence presented and the findings. Along with providing access to support groups, understanding the complexities and subtleties of

the lived phenomenon while treating its causes and symptoms may be helpful for these women. Furthermore, the potential benefits of integrating maternity and interprofessional child healthcare services are addressed: these could possibly lead to the provision of a more-meaningful service, and give postnatal women more opportunity to seek advice and better access to treatment. Timely advice and treatment, and also empathetic care in the early postnatal period, may help to reduce women's anxiety and help them to develop useful strategies to cope with symptoms. However, healthcare practitioners and services should be mindful that the needs of the baby may be prioritized by the mother over her own.

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Sharon Colebrook Hutchens qualified as a physiotherapist from King's College London in 1999. She has worked as a pelvic, obstetric and gynaecological physiotherapist at East Surrey Hospital since 2007. In 2017, Sharon completed a Master's degree in clinical research at the University of Brighton.

Dr Pirjo Vuoskoski has had a long career as a physiotherapist, academic and researcher. She initially graduated as a physiotherapist in 1982, and later completed her Master's degree in physiotherapy in Finland in 2004. In 2014, Dr Vuoskoski completed her PhD at two institutions, the University of Lapland, Rovaniemi, Finland, and Macquarie University, Sydney, New South Wales, Australia. She currently works as a senior lecturer in the Faculty of Sport and Health Sciences (Physiotherapy) at the University of Jyväskylä, Jyväskylä, Finland. Her main research interests lie in experiential phenomena, and the phenomenological approach to physiotherapy and higher education.