Editorial Commentary

The impact of pelvic floor disorders on partners following vaginal birth

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Pelvic organ prolapse (POP) is a common condition that affects the daily lives of those with the disorder. In the article, "Bearing the burden of spill-over effects: Living with a woman affected by symptomatic pelvic organ prolapse after vaginal birth - from a partner's perspective", Mirskaya *et al.* investigated the impact of POP on the partners of individuals with symptomatic prolapse following childbirth (1). Their study is qualitative and utilizes a constructivist grounded theory. The study was conducted in Sweden, and 13 participants were recruited for interviews through purposive sampling. All participants identified themselves as male partners of female patients with symptomatic POP. Participants' responses were used to create a theoretical conceptualization with the core category, "facing a new restricted life" and related categories of "giving up valued activities", "struggling with added demands", "changing intimate behavior", and "redefining future family planning". The findings of the study suggest that symptomatic POP not only affects the patient, but also may negatively affect the partner's life as the burden of this new diagnosis after delivery spills over to the partner. Specifically, the health, sexuality, relationship, and mental wellbeing of partners may be impacted.

While there is existing literature that focuses on how POP after childbirth affects patients, there is limited published literature on the paternal postpartum experience. The literature that has been published is largely related to paternal postpartum depression (2,3). Therefore, the study published by Mirskaya *et al.* is a novel investigation into the partner's experience with POP after childbirth (1). Their use of rigorous qualitative methodology to collect and analyze the data allowed the categories to reach saturation despite the small sample size. Prior to this study, there was only one other study that investigated the effect of pelvic floor dysfunction from traumatic childbirth on partners (4). Given that 25% of women in the United States experience one or more symptomatic pelvic floor disorder, it is an important health issue that continues to be understudied, and this study adds to the limited literature (5).

An additional strength of this study is that it gives insight into the partners' experiences that is actionable. Partners felt that they did not receive adequate counseling or education regarding potential obstetric trauma and pelvic floor disorders resulting from vaginal delivery. During the postpartum course, they also reported inadequate support from healthcare providers when it came to diagnosing and treating POP, which led to the increased burden on the partners. There is evidently opportunity for improved

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education on pelvic floor disorders in both the antepartum and postpartum periods.

While the authors describe the effects of symptomatic POP on patients and their partners, they did not investigate how concomitant pelvic floor disorders may have impacted their results. Other pelvic floor disorders are also prevalent following vaginal delivery with cumulative incidences of 34% for stress urinary incontinence (SUI), 22% for overactive bladder (OAB), and 31% for anal incontinence (AI). The cumulative incidence of POP in this study was 30%, suggesting that many women in the study may have suffered from more than one pelvic floor disorder (6). Due to the negative effects that all pelvic floor disorders have on patients, it is difficult to determine if the burdensome experiences of partners following delivery is the result of solely POP and not confounded by coexisting pelvic floor disorders.

Additionally, the sample recruited for this study is likely not representative of the general population. Though saturation was reached, the sample size was small with thirteen participants. All couples were heterosexual with a shared child, which is not generalizable to the evolving family dynamics in today's society. Also, because participants were recruited through purposive sampling using social media targeted at those who experienced post-birth maternal complications and post-birth adversities, there is likely sampling bias. In future studies, the results may be strengthened by including more participants and using a form of probability sampling for recruitment.

A resounding theme in the interviews conducted by Mirskaya *et al.* is the new restrictions that partners experienced when women developed new symptomatic POP following vaginal delivery (1). Partners reported lifestyle changes such as decreased participation in leisure activities, less exercise, restricted intimacy, and the addition of daily household responsibilities that were previously shared between the couple. These are extremely valid feelings because the postpartum period is notoriously challenging for new parents. Studies estimate that postpartum blues, which consists of mild depressive symptoms, may affect up to 76% of new mothers (7). The high prevalence of postpartum blues makes it difficult to discern if the core category of "facing a new restricted life" can be completely attributed to birth trauma and resulting symptomatic POP. POP may play a role in the restrictions encountered by partners, but it is likely that the partners of women who did not have any birth trauma would also report new restrictions on their lives in the postpartum period.

This study highlights the significant impact that POP can have on a couple after a vaginal delivery. Specifically, symptomatic POP was already known to have negative impacts on the patient, but this study demonstrated the negative effects that spillover onto partners. Partners expressed feeling more restricted in daily life, compromising their physical and mental health in order to overcome the challenges of being with a partner who is suffering from pelvic floor dysfunction. They often struggled to meet the new demands that were imposed, and their relationships became strained. Partners particularly struggled with the decreased amount of intimacy, which was largely due to bothersome symptoms during sexual activity, as well as decreased libido experienced by the female partners. Some couples found the patient's POP to be so debilitating that it influenced their family planning goals, with some couples requesting cesarean deliveries for future pregnancies, and one couple opting for pregnancy termination out of fear of more trauma occurring with a repeat vaginal delivery.

This study demonstrates the public's lack of awareness surrounding pelvic floor disorders. During prenatal visits, providers should discuss the importance of pelvic floor health and how it relates to childbirth. An individual's risk for pelvic floor dysfunction can be assessed and preventative strategies can be implemented for all patients. Patients and partners should be informed that obstetric trauma may occur and there should be some discussion about the potential impacts of birth trauma. Patients should be screened and evaluated for pelvic floor dysfunction in the postpartum period because early intervention is paramount. Should birth trauma occur, patients should be adequately supported and managed in the postpartum period.

Future studies should aim to investigate how other pelvic floor disorders contribute to the partners' experiences following birth trauma. It would also be interesting to compare responses to partners of patients who do not have any type of pelvic floor dysfunction following delivery.

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