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## Exploring Women's Experiences of a Medically Necessary Caesarean

Michelle Cotterell  
*Edith Cowan University*

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Running head: EXPERIENCE OF A CAESAREAN

Exploring Women's Experiences of a Medically Necessary Caesarean

Michelle Cotterell

A Report Submitted in Partial Fulfilment of the Requirements for the Award of  
Honours in Psychology, Faculty of Community Studies, Education and Social  
Sciences, Edith Cowan University.

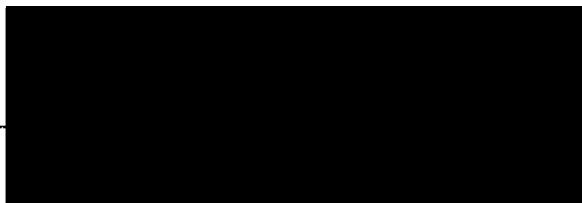
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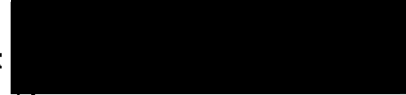
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### Acknowledgments

I wish to thank the women that graciously volunteered to be part of this research project. I thank them for their valuable time, personal stories and all they contributed.

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## Glossary

**Birthweight:** the first weight of infant within one hour of delivery

**Breech Presentation:** Presentation of the fetus during birth with the buttocks or lower limbs first.

**Cephalopelvic Disproportion:** The maternal pelvis is small in relation to the size of the fetal head .

**Cord Presentation:** The position of the umbilical cord. The cord may be 'prolapsed', positioned into the vagina which could interfere with infants circulation when head is positioned on the cervix.

**Failure to Progress:** Inadequate (for safe vaginal delivery) cervical dilation during labour.

**Multipara:** subsequent pregnancies after a previous pregnancy that resulted in live or still birth.

**Parity:** number of pregnancies resulting in live or still birth.

**Placenta Abruptio:** The placenta comes away too early in the pregnancy from the uterine wall.

**Placenta Praevia:** The placenta is positioned over the cervix.

**Postnatal period :** Usually up to 6 weeks after childbirth.

**Post-partum:** Of or occurring in the period shortly after childbirth.

**Pre-Eclampsia:** A serious condition that occurs in 15% of pregnancies, symptoms include rise in blood pressure, swelling of face and appendages, fluid retention, visual disturbance and protein in urine. Pre-Eclampsia can interfere with oxygen provision to placenta and cause damage to mother's kidneys and nervous system.

**Prenatal:** The time preceding child-birth, also called *antenatal*.

**Primipara:** The first pregnancy.

**Puerperal:** Relating to, connected with, or occurring during childbirth or the period immediately following childbirth.

**Very low birthweight:** Birthweight of less than 1500 grams.

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From "Australia's Mothers and Babies 2000", *Australian Institute of Health and Welfare (2003)*. Perinatal Statistics Series no.12. AIHW National Perinatal Statistics Unit, Canberra.

*Retrieved from <http://www.npsu.unsw.edu.au/ps12.pdf>*

Running Head: EXPERIENCES OF A CAESAREAN

Exploring Women's Experiences of a Medically Necessary Caesarean

Michelle Cotterell

### Abstract

Caesarean delivery accounts for approximately one in four births both in Australia and on a global level. Examination of the experience of caesarean delivery is limited, although as caesarean delivery rates are increasing, a practical understanding of the constructs surrounding surgical birth needs to be gained. This review aims to present an overview of the current literature exploring the mother's experience of caesarean delivery. The different modes of medically necessary caesarean delivery, both unplanned and planned are defined. Societal views of caesarean birth as an easier and convenient mode of delivery in comparison to vaginal birth are described and it is suggested that this perception is unjust and misrepresentative of the actual experience. The impact of delivery on appraisal of childbirth satisfaction and the incongruence between personal expectations and delivery are also explored. Psychological adjustment in the post partum is an area of incongruent literature, although qualitative studies are defining the links between caesarean delivery and high rates of anxiety and fear. The association between caesarean delivery and postnatal depression and post traumatic stress disorder is also presented. The importance of the utilisation of qualitative and interactive research methodology to explore the experience of caesarean birth and the practical implications for psychological adjustment after caesarean delivery are discussed.

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Supervisors : Lis Pike  
Paul Murphy  
Submitted: August 2004

## Exploring Women's Experiences of a Medically Necessary Caesarean

### Introduction

The experience of caesarean birth is an area of limited research in Australia. This is surprising as Australia has one of the highest rates of caesarean delivery on a global scale, with approximately one in four infants born after surgical intervention (Walker, Turnbull & Wilkinson, 2004). The psychological adjustment of becoming a mother is compromised by the juxtaposition of the surgical experience and the exuberance felt with the birth of the infant. This review aims to define the different modes of medically necessary caesarean delivery and explore current literature that describes societal expectations of childbirth (Nelson, 2003; Walker, Turnbull & Wilkinson, 2004), personal constructs of childbirth satisfaction (Goodman, Mackey & Tavakoli, 2004), and psychological adjustment after delivery (Affonso & Stichler, 1981). Women's personal reaction to a caesarean birth are different depending on whether the delivery is planned or unplanned (Durik, Hyde & Clark, 2000). Personal experience has found to differ between primipara (first birth) or multiparous (subsequent births) experience (Gamble & Creedy, 2001). The relationship between caesarean delivery and postnatal depression (Koo, Lynch & Cooper, 2003), and post traumatic stress disorder (Reynolds, 1997) will also be addressed.

### *Defining Terminology*

Caesarean deliveries occur for a multitude of reasons, originating from maternal or foetal risk factors. Foetal complications include heartbeat fluctuations, very low birthweight, multiple birth and breech presentation (Australian Institute of Health and Welfare [AIHW], 2000). Maternal complications include pre-eclampsia, failure to progress during labour, placenta praevia, placenta abrupta, cephalopelvic disproportion and cord presentation (AIHW, 2000). Prenatal psychological concerns such as extreme anxiety and fear of childbirth (Ryding, Wijma, Wijma & Rydhstrom, 1998), previous

traumatic birth (Gamble & Creedy, 2001) and mental health issues (Kendell, Chalmers & Platz, 1987) may indicate that a caesarean delivery is a safer birth option (Kirby & Hanlon-Lundberg, 1999) than vaginal delivery.

The caesarean that is essential for the medical and/or psychological well being of the mother/infant dyad is termed the 'medically necessary caesarean' (Schindl et al., 2003). There are two forms of medically necessary caesarean deliveries, unplanned and planned. An unplanned caesarean delivery is usually an emergency, where the immediate delivery of the infant is determined by obstetric intervention. Planned medically necessary delivery occurs if there are foreseeable complications with delivery such as previous birth experiences or prenatal medical conditions.

The use of the terminology 'planned medically necessary' caesarean over the common term 'elective' caesarean was chosen to emphasise that a caesarean delivery for medical necessity does not reflect elective wishes from the mother. Caesarean delivery, chosen by maternal request with no medical or psychological determination, is more definitive of the term 'elective' caesarean. Reasons for chosen surgical birth may include work commitments or child minding options (Eden, Hashima, Osterweil, Nygren & Guise, 2004; Kirby & Hanlon-Lundberg, 1999). This mode of caesarean delivery will not be explored in-depth in this review, which focuses on medically necessary caesarean delivery.

### *Rates of Caesarean Delivery*

Recent Australian statistics indicate that approximately 23.3% of all live births are by caesarean delivery (AIHW, 2000). Western Australian statistics for caesarean birth echo this figure of one in four births (AIHW, 2000; "Under the Knife", 2003). This is comparative with other western countries such as the United States and United Kingdom with rates of 26% and 20% respectively (Walker, Turnbull & Wilkinson, 2004). Australian

statistics which separate the different modes of delivery, ie., emergency or elective do not distinguish between planned medically necessary caesarean delivery and caesareans performed on maternal request (AIHW, 2000). Thus, statistics that report that almost half of the caesarean deliveries in Western Australia and Australia are elective do not represent the figures for caesarean delivery planned for medical necessity. It has been reported that only 2 % of caesarean deliveries in the United Kingdom are elected without medical or psychological origin (Bushe, 2003), thus comparability of overall caesarean statistics could lead us to generalise that this figure may reflect Australian rates.

### *Reasons for Increasing Rates of Caesarean Delivery*

Australian caesarean rates have risen by 35% since 1990 (Walker, Turnbull & Wilkinson, 2002). Possible reasons for this increase include the routine use of ultrasound and foetal monitoring such as cardio tocography (CTG) which measures foetal heart rate and uterine contractions. Therefore, it is possible to determine early signs of foetal distress and prenatal complications in pregnancy or labour (Placek, Taffel & Liss, 1987). Infants with very low birthweight (1000-1499 grams) have a greater chance of being born via caesarean delivery than vaginal delivery (AIHW, 2000). It has become common obstetric practice to deliver infants with breech presentation by caesarean as opposed to feet first delivery (AIHW, 2000; Placek et al., 1987). Rising maternal age may also affect the increasing caesarean rate, as age has been associated with birth complications (Qublan, Alghoweri, Al-Taani, Abu-Khait, Abu-Salem & Merhej, 2002). Threat of legal action has seen obstetricians have a more precautionary outlook in complicated deliveries, thus the aphorism "when in doubt, cut it out" (p. 259, Kirby & Hanlon-Lundberg, 1999). Higher rates of caesarean delivery parallel the decline in neonatal and perinatal death rates (AIHW, 2000).

The acknowledgment that psychological concerns can predispose or contribute to complications during childbirth may have also added to the increase in caesarean rates. Ryding, Wijma, Wijma and Rydstrom (1998) investigated the association between extreme fear of childbirth in the third trimester and delivery by caesarean. Fear of childbirth was defined by Ryding et al. 1998 as high levels of anxiety and minimal ability to cope with stress. Results suggest fear of childbirth is an increased risk factor for an emergency caesarean delivery. Previous sexual abuse has also been associated with anxiety and distress in labour resulting in childbirth complications (Rhodes & Hutchinson, 1994). The understanding that unplanned caesarean delivery is more traumatic physically, emotionally, and psychologically (Schindl et al., 2003) than planned caesarean delivery (Creedy, Shoctet & Horsfall, 2000), suggests that preparing the mother for caesarean delivery is advisable if there are any factors to suggest that a caesarean delivery may be imminent.

### **Expectations of Birth**

During the prenatal period women develop preconceived expectations of the idealised birth and delivery experience. Expectations for birth come from personal experiences, societal and familial views and are moderated by self-perception (Nelson, 2003; Smith, 1999). When expectations are not fulfilled the delivery experience will be appraised as negative and can effect the way one views ones transition to motherhood (Mercer & Marut, 1981).

#### *Social Perceptions*

Although more women are experiencing caesarean delivery than ever before, societal perception of a surgical birth reflect archaic and unjust representations. The journey to motherhood is often portrayed in society as a rite of passage with vaginal delivery worn as a badge and measure of true ability as a mother (Nelson, 2003; Rice &



Naksook, 1998). The caesarean mother is seen as cheating her physiological prophecy and taking the easy delivery mode. Nelson (2003, p. 25) eloquently describes populist cultural mythology of the caesarean mother as "frightening and repellent" to other mothers.

Higher rates of caesarean delivery in private practice than public hospitals (Roberts, Tracey & Peat, 2000) have been sensationalised by tabloid representations of a "too posh to push" attitude exemplifying that caesarean must be simply to avoid the physicality of labour (Barley, Aylin, Bottle & Jarman, 2004; Song, 2004). Mercer and Marut (1981) also describe a societal perception of caesarean birth as a sign of weakness. Given such an atmosphere, it is no wonder that mothers who have experienced caesarean deliveries often report that they feel divested of feelings of motherhood (Rice & Naksook, 1998).

Walker, Turnbull and Wilkinson (2004) reported that Australian women predominantly concede that caesarean births are a facile and convenient mode of delivery. This belief was found regardless of sociodemographic variables such as age, cultural heritage, parity, education and geographical locality. Only women who had personal and past experience of caesarean birth, did not believe that it was an easier mode of delivery. These findings indicate that realistic and non-judgemental representations of caesarean deliveries are needed to balance the prevailing cultural norm.

### *Personal Expectations*

Gamble and Creedy (2001) explored the birth expectation of 310 Australian women in their third trimester. Women answered a four part questionnaire designed to measure sociodemographic variables, details of current pregnancy, anxiety and past obstetric history. Women were asked to state their preferred mode of delivery, from spontaneous vaginal with no pain relief to caesarean section and to comment on reason for birth option. With no difference found for any sociodemographic variables, vaginal births were the expected delivery experience for 93.5 % of the sample. Of the women that

expected vaginal birth, 54.8% preferred to attempt a labour free of pharmacological intervention, or with nitrous oxide which is a low risk pain relief option (National Collaborating Centre for Women's and Children's Health, 2004). More primiparas than multiparous women expected intervention free vaginal delivery.

The sample of 310 women included 40 women who had experienced previous caesarean sections, of these 27 stated a preference for this pregnancy to be a vaginal birth after caesarean (VBAC). Reasons for this delivery choice included wanting to experience a 'normal' birth and the perception that recovery would be quicker and easier (Gamble & Creedy, 2001) as there are a greater number of physical health problems after caesarean birth (National Collaborating Centre for Women's and Children's Health, 2004) and a greater chance of hospital readmittance within the first 8 weeks post partum (Thompson, Roberts, Currie & Ellwood, 2002).

Only 6.4% of women in Gamble and Creedy's (2001) study preferred to have a caesarean birth. Of these 20 women, 19 had obstetric complications, mainly previous emergency caesarean delivery and complicated birth. The majority of the women expressed negative thoughts concerning their previous delivery although they understood that surgical delivery was for the health and safety of their child (Gamble & Creedy, 2001). There was only 1 participant (0.3% of the total sample) that chose a caesarean delivery for no obstetric reason. Thus, it seems that a caesarean birth is not an expected option for most mothers unless past experience or medical reasons dictate otherwise. Further research is needed to explore the belief systems that pertain to the intrinsic belief of most women that vaginal birth is the expected and primary mode of delivery.

It may be that prenatal classes do not adequately explore the possibility that at least one in five women will deliver via a caesarean section (Greene, Zeichner, Roberts, Callahan & Granados, 1989). As women's personal belief systems do not include the possibility that a surgical delivery could happen (Murphy, Pope, Frost & Leibling, 2003),

it is important that a realistic portrayal of the spectrum of possible birth experience be made available in pre-natal classes. Information that is self-relevant is likely to be integrated into the personal repertoire of expectations, whereas information that seems on the periphery will not be actively absorbed (Smith, 1999). Preparatory information on surgical delivery can impact upon positive recovery and post birth expectations (DiMatteo et al., 1996; Greene et al., 1989), suggesting that preparation could buffer against the negative appraisal of the surgical delivery.

### *Self-Identity*

The theoretical model of the relational self (Smith, 1999) is a plausible explanation of women's development of personal expectations in pregnancy. The relational self is described as the personal self-identity built upon the convergence of social identity and self-perception. Thus one's relational self is moderated by social interaction and the roles that one sees oneself as performing (Smith, 1999). Redefining one's relational self can occur during role transition, such as pregnancy and parenthood. Pregnant women envisage an idealised view of their role as a mother (Smith, 1999) and vaginal birth is the beginning of that journey (Murphy, Pope, Frost & Leibling, 2003). The family system is part of the personal relational self. Women elucidate new roles for their spouse and extended families that help to validate her personal self identity through her social identity and reinforce her transition to her new role (Smith, 1999).

If the delivery experience is incongruent with personal and familial expectations, the women may question her self-identity. Questioning self-identity is associated with lower levels of self-esteem (Smith, 1999). In a comparative study of 20 women that delivered via unplanned caesarean with 30 women that delivered vaginally, Mercer and Marut (1981) concluded that women's self-esteem is lowered by unplanned caesarean delivery. The factors associated with caesarean birth that lowered self-esteem were;

perceived social stigmatisation, incompatibility with personal and familial expectations, changes in body image, sense of failure, lack of positive reassurance concerning delivery and loss of personal control during the delivery. Low levels of self-esteem also affected appraisal of the delivery experience. Childbirth satisfaction was appraised as negative if the women felt that it was not reflective of their ability to enter motherhood.

#### *Satisfaction and Birth Experience.*

Goodman, Mackey and Tavoki (2004) report that personal control is a definitive predictor of childbirth satisfaction. Low levels of control over the delivery are associated with lower levels of childbirth satisfaction. Women who had delivered by unplanned caesarean reported the lowest levels of control over the delivery, thus the lowest levels of satisfaction (Goodman et al., 2004). In contrast, women report that a degree of control is maintained in planned caesarean delivery (Durik, Hyde & Clark, 2000). Thus as expected, planned caesarean deliveries are not rated as low in satisfaction as unplanned caesarean delivery.

High levels of labour pain and discomfort was also a predictor of low childbirth satisfaction (Goodman, Mackey & Tavoki, 2004; Saisto, Salmela-Aro, Nurmi & Halmesmaki, 2001). Many women who had emergency unplanned caesarean births had experienced long labours and extended physical pain thus, caesarean deliveries were rated as the most disappointing deliveries (Saisto et al., 2003). It was also suggested that dissatisfaction with post-partum pain relief predicted low levels of childbirth satisfaction. Women reported needing greater amounts of pain relief after caesarean birth than vaginal birth and were more likely to report that the pain relief was inadequate (Saisto, et al).

Satisfaction with the delivery experience may also be affected by post partum events (Cranley, Hedahl, & Pegg, 1983). Ability to breastfeed successfully can provide a positive event that buffers the negative appraisal of the delivery experience (Patel,

Liebling & Murphy, 2003), whereas, difficulties with breastfeeding can reinforce the disappointment with delivery (Reynolds, 1997). There is evidence to suggest that caesarean delivery may impede breastfeeding (Cranley, Hedahl, & Pegg, 1983; Rowe-Murray & Fisher, 2002) as surgical delivery often means that mothers experience long periods of time between birth and contact with their newborn, thus effecting a delay in important initial feeding opportunity (Rowe-Fisher & Murray, 2002). A further complicating factor is that the abdominal wound can present difficulties with the physicality of lifting the baby to feed comfortably. Cranley et al. (1983) found that rates of breastfeeding after emergency caesarean delivery are much lower, 55%, in comparison to the 90% breastfeeding rate following vaginal delivery.

Childbirth satisfaction is also related to parity and may be a predictor of future childbirth options (Schindl et al., 2003). There are a greater number of expectations for a first birth than for subsequent births (Gamble & Creedy, 2001). Schindl and colleagues explored the relationship between mode of delivery for a first child and the hypothetical choice of delivery mode for future pregnancies of 1050 women. It was reported that of the 93 women who experienced an unplanned caesarean as a first birth only 30.1% would consider a subsequent caesarean birth. In comparison 83.5% of the 903 women that delivered vaginally would repeat their personal experience. In contrast to unplanned caesarean delivery, 66% of the 147 women who had medically necessary planned caesareans would be satisfied with delivering in the same manner. This was due to the time for preparation of birth experience and adjustment to their previous birth expectations (Schindl et al.)

#### *Differences in Experience between Unplanned and Planned Caesarean Birth.*

As well as differences between vaginal and caesarean birth, there are also differences between the experiences of medically necessary planned and unplanned

delivery (Cranley, Hedahl & Pegg, 1983; Durik, Hyde & Clark, 2000). Whilst both experiences may share similar social stigmatisation (Walker, Turnbull & Wilkinson, 2004), physical post-partum difficulties, and disappointment that a natural birth was not possible (Murphy, Pope, Frost & Leibling 2003) the appraisal of the delivery is dissimilar (Durik et al., 2000).

Unplanned caesarean delivery is often appraised in a more negative fashion than planned caesarean delivery (Cranley, Hedahl & Pegg, 1983; Durik, Hyde & Clark, 2000). Appraisal is affected by the sense of urgency that accompanies the unplanned caesarean, thus causing anxiety and fear for the mother concerning the delivery (Affonso & Stichler, 1981). The mother's negative appraisal continues post-delivery due to the feelings of failure or disappointment because of the necessity of intervention in childbirth (Murphy, Pope, Frost & Leibling 2003). Cranley et al. (1983) asked new mothers to rate their delivery experience as predominantly positive or predominantly negative and reported that whilst 35% of emergency unplanned caesarean deliveries were rated as negative, only 9% of the planned caesareans were rated similarly. When interviewed, the mothers that had rated the emergency delivery as negative cited reasons such as feelings of missing out and not realising personal expectations. Mothers that had planned caesareans described the delivery with more indifference and as meeting their expectations.

Planned caesarean delivery is assessed dependent upon complications that are present in pre-natal assessments. The obstetrician can educate and prepare the mother concerning the necessary delivery. This time period also allows the mother to re-evaluate whether mode of delivery is important for self-identity and adjust personal expectations to be congruent with anticipated birth event (Cranley, Hedahl & Pegg, 1983; Durik, Hyde & Clark, 2000). A sense of control during the delivery is still achievable for the mother, which is lost in unplanned caesarean delivery (Cranley et al., 1983). Experiences such as the father cutting the umbilical cord and the parents holding the baby immediately after

delivery are possible with a planned caesarean providing a childbirth experience that is comparable to vaginal birth (Cranley et al). Breastfeeding rates for planned caesarean births, 72%, are also higher than emergency deliveries, 55%, reinforcing that planned caesarean birth is appraised in a more positive manner (Cranley, et al.).

### **Psychological Adjustment after Caesarean Delivery**

Puerperal psychological adjustment has been measured by assessing levels of anxiety, depression and ability to cope with the new demands of motherhood (Padawer, Fagan, Janoff-Bulman, Strickland & Chorowski, 1988). Due to the immense differences in delivery experience between vaginal and caesarean birth, it is expected that there will be differences in psychological adjustment. Much literature links the high levels of birth trauma from caesarean deliveries with high levels of anxiety (Affonso & Stichler, 1981), postnatal depression (Koo, Lynch & Cooper, 2003) and problems with mother/infant interaction (Ballard, Stanley & Brockington, 1995). There is also a growing body of literature that reports links between caesarean delivery and post-traumatic stress disorder (Reynolds, 1997) and posttraumatic intrusive stress reactions (Ryding, Wijma & Wijma, 2000).

As with much of the research exploring the experience of caesarean birth, there are inconsistent findings concerning psychological adjustment in the post partum. Minimal literature has reported that there are no statistical differences in psychological adjustment relative to mode of delivery. Padawer, Fagan, Janoff-Bulman, Strickland and Chorowski (1988) measured anxiety, depression and confidence in mothering 24 to 48 hours post-birth in 44 women and found no difference between vaginal and caesarean delivery. The relevance and generalisability of this study was questionable due to the numerous limitations (e.g., non representative sample, period of measurement) which will be addressed in this review.

The immediate post-partum period is a time of euphoria and excitement about the wonder of new life. The joy of the health of the baby and wonderment as the parents greet their new family member may overshadow any concerns of the delivery mode. Thus, immediate measurement for depression or anxiety would be ineffectual in the initial stages. It is possible that within the few months following delivery a more negative appraisal of birth experience can occur. Reflection and retrospective recall can actualise negative appraisal as mothers retelling of their experiences may realise that expectations were not met (Waldenstrom, 2004). Mothers may have also been affected by pain medication, such as morphine (which is a common relief for the discomfort of the abdominal wound) thus effecting any immediate appraisal of childbirth (National Collaborating Centre for Women's and Children's Health, 2004).

The new mothers in Padawer et al's (1988) study were in a supportive and helpful hospital environment. The manner of treatment from hospital staff has been shown to effect appraisal of birth (Ryding, Wijma & Wijma, 1998). All the women in the study had undergone pre-natal classes, which included preparing for caesarean delivery, and all women had spousal support in the delivery room or operating theatre. Both of these factors have been linked to a more positive appraisal of the caesarean experience (Cranley, Hedahl & Pegg, 1983). As many women that deliver via caesarean do not have these extraneous support systems (AIHW, 2000), it is probable that the women in this study were not a representative sample. Follow up at 3 and 6 months post-partum may have also told a different story about further post-partum psychological adjustment.

#### *Anxiety and Fear after Caesarean Birth*

Affonso and Stichler (1981) interviewed 104 women 2 to 4 days after their caesarean delivery and reported that 92% expressed feelings of anxiety and fear. The anxiety was directed at concern for self and infants' health. Women also described that high levels of anxiety influenced their ability to perceive the immediacy and distress of the



surgical delivery and chain of events leading to the birth. Women described heightened perceptions to detail and perhaps even surreal accounts of the event as they experienced it. Seemingly unimportant and minute details were captured and recalled, which may express an attempt for control and realism in an otherwise unexpected and alien environment. For many women a surgical birth may be their first surgical or anaesthetic experience, which may heighten feelings of anxiety even further. Anxiety was also felt due to the physical pain and exhaustion that many mothers' had experienced during prolonged labours and complications, before the decision was made for caesarean delivery. Women were also anxious about the expected pain that would result from surgery. Ability to care for the baby whilst in pain also factored into heightening anxiety levels (Affonso & Stichler, 1981).

Fear for ones self and the baby was comorbid with anxiety (Affonso & Stichler, 1981). The experience of caesarean delivery can be seen by the women as threatening her physical well-being and as a sign that there are problems with her infant. It was noted that one particular fear was death, either for ones self or the infant (Affonso & Stichler, 1981). Some women recalled having thoughts that they would die from complication with the surgery. Affonso and Stichler describe women's thoughts pertaining to how their infant would be cared for as they describe the thought that their death was a possibility during the caesarean. Women also recalled praying and hoping during the surgical delivery that their baby would live. As many babies are taken briefly to special care after caesarean deliveries for suctioning of mucous or general monitoring, this is a genuine fear that caregivers need to address (National Collaborating Centre for Women's and Children's Health, 2004). The removal of the baby immediately following delivery can heighten mothers' anxiety and fears (Affonso & Stichler, 1981). Women need to be reassured of their babies' health status to help dissipate these thoughts.

*Post-Natal Depression*

Current literature suggests that the relationship between the occurrence of post-natal depression (PND) and caesarean delivery appears incongruent and complex. PND is a multidimensional mood disorder with heterogeneity in the possible symptomatology. There is a lack of understanding of the causal factors and possible personal predispositions for PND (Hauptberger, 1997). Some research has indicated that a biopsychosocial explanation of the casual factors of PND is the most adequate, integrating factors such as degree of social support, spousal interaction and delivery experiences. Initial symptoms include lethargy, mood swings and inability to cope with demands of the infant and/or family (Hauptberger, 1997).

PND affects around 14 % of Australian women (Hauptberger, 1997), which is consistent with global rates (Gotleib, Whiffen, Wallace & Mount, 1991). The Edinburgh Post-natal Depression scale (EPDS) is a commonly used measure for diagnosis of PND in Australia, the United Kingdom, Europe and the United States (Cox, 1986). This scale is a self-report questionnaire comprised of series of 10 items relating to general mood and well being of the mother and scored accordingly on a scale of 0 to 3 with a possible score of 30. A score of 12 or over is considered a risk for PND (Cox, 1986). EPDS has been shown to have validity and reliability as a measurement tool (Webster, Pritchard, Creedy & East, 2003). All studies (with the exception of the study by Saisto et al., 2001, as this research looked at personal traits such as anxiety) mentioned within this review use the EPDS as a measure of PND.

As noted there is an inconsistent view in the literature between PND and caesarean delivery. Some research has suggested that mode of delivery is not a statistically significant predictor of PND (Symon, MacDonald & Ruta, 2002). Symon et al (2002) measured quality of life scores obtained from women rating the importance of their physical, psychological, social and economic needs being met in the post partum. These

scores were correlated with scores on the EPDS and it was found that women who rated lower and more negative life quality scores had a greater chance of scoring higher on the EPDS. Interestingly, it is suggested that whilst inability to reach statistical significance of delivery mode as PND predictor, women report that health concerns such as soreness of caesarean scar are a measure of negative appraisal of coping after birth and effect quality of life (Symon et al., 2002), thus relating a higher score on the EPDS.

Saisto, Salmela-Aro, Nurmi and Halmesmaki (2001) explored the relationship between psychosocial factors and delivery satisfaction as being able to predict depression in the post-partum period. It was reported that disappointment in delivery and intense pain in labour were the strongest predictors of depression. Whilst no statistically significant link between caesarean delivery and depression was found, it was reported that caesarean delivery was the greatest predictor of delivery disappointment. Thus, indirectly caesarean delivery can contribute to the onset of PND.

Other research has reported more direct links between caesarean delivery and PND. Koo, Lynch and Cooper (2003) identified that women who undergo emergency delivery, such as unplanned caesareans, have a two-fold risk of developing PND in comparison to women that experience non-emergency delivery. This study suggested that the stress produced from the emergency circumstances would precipitate a greater risk for developing PND (Koo et al., 2003). Factors such as social support and inadequate hospital care were controlled for as minimal social support and dissonance of care providers has been shown to influence the risk of PND (Brugha et al., 1998; Ryding, Wijma & Wijma, 1998). It was concluded that the higher scores on the EPDS at 6 weeks post partum was indicative of the emergency delivery and the experiences within this mode of delivery. Longitudinal follow up of these findings would substantiate the association between PND and emergency delivery as onset of PND can occur anytime within the first year after childbirth (Cox, 1986).

Further evidence to suggest that a direct link between caesarean delivery and PND is the link between severe 'baby blues' and later onset of PND (Glover, Liddle, Taylor, Adams & Sandler, 1994; Webster, Pritchard, Creedy & East, 2003). Baby blues is a common mood disorder affecting around 80% of mothers at 2 to 5 days post-partum. Baby blues can be mild to severe (Cox, 1986). Mild baby blues is characterised by irritability and weepiness and more severe baby blues includes extreme unhappiness, emotionalism and lethargy (Cox, 1986). Women who experience caesarean delivery are more likely to have more severe baby blues in comparison to women who have had a vaginal delivery (Webster et al, 2003).

To determine if severity of baby blues was related to specific constructs of the unplanned delivery, such as disappointment and dissatisfaction, or the physiological stress of abdominal surgery, levels of emotionalism over 10 days were compared between women who had undergone an emergency caesarean and women who had undergone an elective hysterectomy (Kendell, Mackenzie, West, McGuire & Cox, 1984). Results suggest that the participants in the caesarean condition rated high emotionalism at a 5-day peak whereas the hysterectomy condition reported no change in emotionalism over the time. These findings reinforce the possibility that mode of delivery can attribute to development of PND.

As previously suggested PND is a multifaceted mood disorder that needs further research to define a greater understanding of the casual factors and precise symptomatology. It may be that the inability of some studies to define direct links between caesarean delivery and PND is a function of the heterogeneity of the disorder or inadequate measurement tools. If further research can relate caesarean delivery and later onset on PND, the immediate post partum period becomes a critical time for women to be provided with counselling or reflection to discuss delivery experiences. It is important to try to forge a greater understanding of the need for the surgical delivery and the

importance of enhancing the positive side to the experience ie., the health and safety of the mother and infant.

### *Traumatic Birth Experience*

Recent research has suggested an association between caesarean delivery and posttraumatic stress disorder (PTSD) (Reynolds, 1997) or posttraumatic intrusive stress reactions (PTISR) (Ryding, Wijma & Wijma, 1998a). The Diagnostic and Statistical Manual of Mental Disorders 4<sup>th</sup> edition, text revision, (DSM-IV-TR, 2000) describes PTSD as occurring after experiencing an event with perceived or actual threatened death or serious injury and the presence of intense fear and helplessness. The disorder manifests with reliving the experience in various distressing ways including dreams or flashbacks. The individual reacts by avoiding any events associated with the initial incident and is devoid of response and emotion especially concerning the event. The individual also exhibits hyperarousal such as irritability and insomnia (DSM-IV-TR, 2000). PTISR are similar to PTSD, and describe distressing and invasive reactions to, and recollections of, the experience (DSM-IV-TR, 2000; Ryding et al., 1998b). The studies mentioned in this review use the criteria of DSM-IV-TR for diagnosis of PTSD.

Ayers and Pickering (2001) suggest that the revision of the criteria for PTSD (the inclusion that perceived threat to life is a possible trigger event) has enabled diagnosis to be more applicable to childbirth. Ryding, Wijma and Wijma (1998a) suggest that caesarean delivery, in particular unplanned emergency deliveries, do fulfil this criteria. Other research (e.g. Creedy, Shochet & Horsfall, 2000) forward the idea that puerperal PTSD and similar traumatic childbirth reactions should not be blanketed under the general PTSD criteria, but should be allocated particular sub-streams that are relevant to childbirth trauma. Greater understanding and defining of PTSD is also needed to avoid possible

misdiagnosis of trauma disorders with PND, although it is also possible that PTSD may be comorbid with PND (Reynolds, 1997).

It is difficult to determine how many women are affected by acute trauma after childbirth, and then the causal factors that progress to PTSD or posttraumatic intrusive stress. Ryding, Wijma and Wijma (1998a) reported that up to 55% of women that delivered by emergency caesarean section experience severe traumatic reactions such as intense fear. Other studies have reported that around 33% of women experience traumatic births (Creedy, Shochet & Horsfall, 2000; Ryding, Wijma & Wijma, 1998b), followed by involuntary post-partum reactions such as disturbing images and memories (Ryding et al., 1998b). Diagnosis of PTSD is less frequent with figures of between 1.5% and 5.6% reported in recent literature (Ayers & Pickering, 2001; Creedy et al., 2000).

Creedy, Shocet and Horsfall's (2000) large-scale study of the prevalence of puerperal PTSD in Australian women suggests there are two predicting factors, the level of birth intervention and perception of post-partum care, which distinguish women that are diagnosed with PTSD as opposed to women who have experienced birth trauma. These findings are consistent with previous studies from United Kingdom and Europe (Menage, 1993; Ryding, Wijma & Wijma, 1998) that note that higher levels of obstetric intervention, such as emergency caesarean, and dissatisfaction with hospital care are associated with diagnosis of PTSD.

It is suggested that obstetric intervention is associated with onset of PTSD as women appraise the surgical delivery with extreme negative and emotive attributes. Ryding, Wijma and Wijma (2000) suggest that women's recollections of obstetric intervention can be classified in four distinct categories; confidence in whatever happens, positive expectations turning into disappointment, fears come true, confusion and amnesia. Negative appraisal occurred when delivery experiences were categorised as positive turning into disappointment and fears coming true. These categories of delivery experience

describe women that were angry and resentful that their birth did not go as anticipated (Ryding et al., 2000).

Projection of negative feelings toward the infant is a precursor to negative recalling of obstetric intervention. Ryding et al. describes women feeling as if their infant was not their baby or was not real. It has also been noted that babies born via caesarean are named ambivalently in comparison to babies born via vaginal births (Mercer & Marut, 1981). Some women also have problems coping with the physical pain from surgery and then the demands that infant care places upon them. Ballard, Stanley and Brockington (1995) describe a case study of an emergency caesarean in which the woman recalls being held down on the operating table in agony as her infant was delivered. The woman blamed the baby for the pain and experience she had to birth him.

The other predictor associated with the onset of PTSD was dissatisfaction with hospital care (Creedy, Shocet & Horsfall, 2000; Gamble & Creedy, 2000). Women perceived that the hospital staff was to blame for the traumatic delivery (Ryding, Wijma & Wijma, 1998a, 1998b). Women described feeling angry toward staff and believed that nurses and midwives did not understand their personal feelings about the delivery. Some women believed that the surgical delivery could have been avoided. Creedy et al. (2000) note that mothers feel a lack of respect from staff when they are excluded from decision making processes and not forewarned of delivery procedure. Inadequate post partum pain management was also a predictor of dissatisfaction with hospital care.

As previously mentioned, many women that have had an unplanned caesarean delivery will opt for a planned caesarean for subsequent deliveries (Gamble & Creedy, 2001). This is to avoid the feelings of fear and anxiety in a hope to appraise the subsequent delivery in a more positive manner. Reynolds (1997) suggests that avoidance behaviour is typical of diagnosis of PTSD. The women elect a planned caesarean to avoid the labour or traumatic event that precipitated the previous delivery. The positive appraisal of the

planned delivery may also relieve negative feelings generated from the initial traumatic delivery (Reynolds, 1997).

### **Methodological Issues In Exploring Caesarean Birth.**

As explained throughout this review there are inconsistencies in the literature exploring caesarean birth. Of course, this may be a product of the individual quality of the experience, although it is interesting to note that some studies (e.g. Saisto, Salmela-Aro, Nurmi and Halmesmaki, 2001; Symon, MacDonald & Ruta, 2002) report that findings did not meet statistical significance. It is pertinent to question if the constructs are not relevant or the measurement tools are appropriate for the construct that are being explored.

Much research uses quantifiable scales and structured questionnaires to attempt to explore the experience of childbirth (e.g., Cranley et al.; Gamble & Creedy, 2001). It is suggested that this experience may be captured in a more illustrative manner using qualitative methodology such as semi-structured and conversational style interviews and thematic analysis. The rationale for this methodology pertains to the emotive content of mothers' deeply personal experiences and their individual manner of retelling their story (Smith, 1994, 1999; Murphy, Pope, Frost & Libeling, 2003; Nelson; 2003). Smith (1994, 1999) suggests that surveys and rating scales do not capture distinct qualities and uniqueness that an experience such as childbirth presents; it distracts from the personal meaning to reduce an emotion to a verb for ease of measurement and analysis.

The richness of personal accounts of caesarean deliveries is evident in studies that combine quantitative and qualitative methodologies. For example, Cranley, Hedahl and Ross (1983) asked women to clarify their ratings of positive or negative perceptions of childbirth thus enlightening the researcher to why women with seemingly similar experiences (e.g., unplanned caesarean delivery) may be rated in a contrasting manner. Interviewing also allows for the impact of personal beliefs and cultural traditions to be



realised. Rice and Nansook (1998) interviewed Thai women in Australian hospitals that had experienced caesarean birth and found that part of their disappointment with the surgical delivery was due to the inability for them to perform traditional post-birth rituals. This is just an example to highlight that personal expectations in the childbirth experience could be excluded if explored with non-interactive measurement tools. It is the personal extracts of women's experiences that will provide the salient issues that need to be addressed during puerperal psychological adjustment.

### **Future Possibilities**

The majority of Australian research surrounding the experience of caesarean delivery uses predominantly quantifiable data to portray the constructs associated with caesarean delivery. Although interviews or women's personal comments may be part of the overall data collection, it seems that the true worth of the women's personal stories is not utilised. The qualitative research that is evident throughout the general literature seems only viable to expand on the findings that quantifiable measures gathered, and is not valued in its own right. Much of the research also seems to be comparative between delivery modes. The limited studies, mainly European in origin, that use qualitative methodologies, such as phenomenological inquiry, to tap into the women's real experiences, facilitate a more fluid understanding of the complexities, personal uniqueness yet undeniable similarities in birth stories. It has been shown that birth stories are an under-utilised but effective education resource for care providers, such as nurses, midwives and counsellors (VandeVusse, 1999). Therefore, exploration of narratives of caesarean experiences could provide a foundation to facilitate appropriate and effective post partum care to maximise psychological adjustment.

### **Conclusion**

Caesarean delivery, both planned and unplanned has become a routine part of obstetric experience. As more women have surgical deliveries it is important to realise that

their experiences, from their prenatal expectations to post-partum satisfaction differs markedly from vaginal births. Preparation for caesarean delivery may counteract the negative appraisal that often occurs post childbirth. Changing societal perceptions towards a more realistic viewpoint, although a difficult task, would also help women to accept that caesarean birth is a necessary and vital part of becoming a mother for many women. Recognition that the psychological adjustment for women after surgical birth may be arduous and involve more extensive care than vaginal delivery is a factor that may lessen the later onset of depression or trauma disorders.

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Running Head: EXPERIENCES OF A CAESAREAN

Exploring Women's Experiences of a Medically Necessary Caesarean

Michelle Cotterell

### Abstract

Caesarean delivery accounts for approximately one in four births both in Australia and on a global level. Examination of the experience of caesarean delivery is limited, although as caesarean delivery rates are increasing, a practical understanding of the constructs surrounding surgical birth needs to be gained. Much research has explored caesarean birth in terms of the experience as comparable to other modes of delivery and peripheral events, such as societal views that can impact on the overall experience. The present study aims to attempt to understand the unique and personal interpretation the woman makes of her experience, through exploring the pre-birth, delivery and post-partum constructs that occur during a medically necessary caesarean birth procedure. An interpretative phenomenological approach was utilised with conversational style interviews of 18 women. The interviews were transcribed verbatim and two superordinate themes emerged after initial individual analysis with a network design and overall analysis with a thematic conceptual matrix of birth experience and post partum events. The superordinate themes of disappointment and acceptance were directly related to mode of delivery, unplanned or planned. High incidence of traumatic delivery and post-natal depression were found amongst women that experienced unplanned caesarean deliveries. Women perceived post partum care to be inadequate and it is suggested that care needs to be reflective of delivery context.

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## Exploring Women's Experiences of a Medically Necessary Caesarean

### Introduction

One in four births in Western Australia is via caesarean delivery (Australian Institute of Health and Welfare [AIHW], 2000). Whilst the multitude of research on caesarean sections is concerned with the expectations and preparation that a mother may have for this surgical birth procedure, research into the women's interpretation of the experience of the caesarean delivery is limited. By interviewing women who have experienced their first caesarean delivery, we may attempt to understand the unique and personal interpretation the woman makes of her experience. This study aims to explore the pre-birth, delivery and post-partum constructs that surround the experience of the mother during a medically necessary caesarean birth procedure.

The caesarean that is essential for the medical and/or psychological well being of the mother/infant dyad is termed the medically necessary caesarean (Schindl et al., 2003). There are two forms of medically necessary caesarean deliveries, unplanned and planned. An unplanned caesarean delivery is usually an emergency situation. It can occur during or before the onset of labour if it is determined that delivery must be immediate for the health of mother or infant. The planned medically necessary delivery can occur if there are foreseeable complications with delivery such as previous birth experiences or prenatal medical conditions.

Recent Australian statistics suggest that 23.3% of live births are via caesarean delivery and that this figure has increased by 35% since 1990 (AIHW, 2000; Walker, Turnbull & Wilkinson, 2002). Western Australian statistics for caesarean delivery echo this figure of one in four births (AIHW, 2000; "Under the Knife", 2003). This is comparative with other western countries such as the United States and United Kingdom with rates of 26% and 20% respectively (Walker et al., 2004).

Previous research has taken a peripheral approach, looking at caesarean delivery in terms of societal perceptions (Walker et al., 2004), personal delivery expectations and the role of childbirth as definitive to the journey into motherhood (Rice & Naksook, 1998). These studies unanimously reflect that caesarean delivery is perceived as a futile mode of delivery as pregnant women envisage an idealised view of their role as a mother (Smith, 1999) and vaginal birth is the beginning of that journey (Murphy, Pope, Frost & Leibling, 2003). If the delivery experience is incongruent with personal and familial expectations, the woman may question her self-identity. Mercer and Marut (1981) concluded that women's self-esteem is lowered by factors associated with caesarean birth such as; perceived social stigmatisation, incompatibility with personal and familial expectations, changes in body image, sense of failure, lack of positive reassurance and loss of personal control during the delivery.

Research exploring childbirth satisfaction has used comparative measures to define the place of caesarean delivery on the delivery spectrum. In comparison to vaginal delivery, women are less likely to want a caesarean delivery and to experience negative thoughts concerning their delivery after caesarean birth (Gamble & Creedy, 2001). As expected there are also differences in post-partum psychological adjustment after caesarean delivery. Much literature links the high levels of birth trauma from caesarean deliveries with high levels of anxiety (Affonso & Stichler, 2003) and problems with mother/infant interaction (Ballard, Stanley & Brockington, 1995).

There are tentative links between caesarean delivery and severe baby blues (Glover, Liddle, Taylor, Adams & Sandler, 1994; Webster, Pritchard, Creedy & East, 2003) and subsequent onset of post-natal depression (Koo, Lynch & Cooper, 2003). A growing body of literature is emerging suggesting links between caesarean delivery and post-traumatic stress disorder (Creedy, Shochet & Horsfall, 2000; Gamble & Creedy, 2004; Reynolds, 1997; Ryding, Wijma and Wijma, 1998a, 1998b) and posttraumatic

intrusive stress reactions (Ryding, Wijma & Wijma, 2000). There have also been suggestions that the extended period of separation of the mother from the newborn, that occurs after surgical delivery has been linked to lower rates of breast-feeding (Cranley, Hedahl, & Pegg, 1983; Rowe-Murray & Fisher, 2002).

Women's experiences of planned and unplanned medically necessary caesarean deliveries have been shown to differ (Cranley et al., 1983; Durik, Hyde & Clark, 2000). Whilst both experiences may share similar social stigmatisation (Walker et al., 2004), physical post-partum difficulties, and disappointment that a natural birth was not possible (Murphy et al., 2003), unplanned caesarean delivery is often appraised in a more negative fashion than planned caesarean delivery (Cranley et al., 1983; Durik et al., 2000). Appraisal is affected by the sense of urgency that accompanies the unplanned caesarean, thus causing anxiety and fear for the mother concerning the delivery (Affonso & Stichler, 1983). The negative appraisal continues post-delivery due to the feelings of failure or disappointment due to the necessity of intervention in childbirth (Murphy et al., 2003).

Although the aforementioned research explored constructs that encapsulate the experience of a medically necessary caesarean delivery, there is a lack of research that is concerned with understanding the meaning and the personal interpretation of the caesarean delivery to the women. The handful of qualitative studies that explore childbirth from an interpretative phenomenological perspective are predominantly European in origin (Murphy et al., 2003; Ryding et al., 1998a, 1998b, 2000). As statistics suggest that the rate of medically necessary caesarean delivery is increasing in Australia there needs to be Australian research that reflects how women interpret this experience. This study aims to explore the pre-birth, delivery and post-partum constructs that encapsulate the experience of the mother during a medically necessary caesarean delivery. The women's stories will shape the themes and constructs that will be generated.



## Methodology

### *Research Design*

The research design for the present study utilised an interpretive phenomenological approach, adhering to hermeneutical principles of research, as synthesised by Addison (1992) and Conroy (2003). An interpretive phenomenological approach explores individual subjective experiences through active dialogue. The present research was founded on the premise that the researcher-participant dyad is dynamic. Thus, exploration of the researched phenomena occurred with conversational style interviews that were flexible, using participants' narratives to develop and refine the interview direction.

An adaptable interview schedule was developed before the onset of interviews to be used as a prompt to refocus or direct conversation. The questions were derived from the researcher's personal experience of her two medically necessary caesarean deliveries and literature that described women's narratives about their birth experience (e.g. Murphy et al, 2003; Ryding et al., 2000). The interview questions were initially designed to explore the caesarean delivery by asking participants about contextual descriptions, their personal thoughts of the birth experience and the emotions involved within this experience.

Following a pilot study based on this interview schedule with three women, the researcher refined the interview schedule to encapsulate the experience of the caesarean delivery in a time sequential manner, exploring pre-birth, birth and post-birth context, thoughts and feelings (Appendix A). With each progressive interview the prompts and questions were adapted to assimilate into the unique conversation dynamic of the research-participant dyad, thus grounding the data within the accumulated experiences of the research participants. The inclusion of questions concerning possible experience of post-natal depression (PND) after medically necessary caesarean delivery were integrated after two of the three women in the pilot study disclosed that they had been treated for PND.

*Paradigms and Assumptions*

Hermeneutical principles of research are drawn from an ontological philosophy, emphasising that an individual finds meaning in an experience through their personal interpretation of an event (Becker, 1992; Conroy, 2003). An individual's interpretation of an experience is contextually biased and fluid, ever changing as new experiences affect and influence how we interpret our world (Conroy, 2003; Smith, 1994). The researcher is an active participant within the study as the manner that the interviewed participant discloses their experience is determined by the dialogue that the dyad engages in.

An interpretive phenomenological approach looks at everyday experiences and the meaningful interpretations that can arise from these events as worthy phenomena to study (Becker, 1992; Conroy, 2003). This provides a sound rationale to choosing an event such as childbirth to study using this methodology. Whilst childbirth may only happen a handful of times either in the immediate or periphery of one's own life, childbirth is an everyday event in a global context (World Health Organisation, 2003).

*Sample*

An interpretive paradigm suggests that 12 to 15 participants will provide saturation of themes and concepts relevant to the research aim (Miles & Huberman, 1994; Munhall, 1994; Smith, 1994, 1999). Participant criteria were determined, as boundaries framing the context of the experience, strengthens participant and data representativeness and dependability (Nagy & Viney, 1994). Purposeful sampling (Patton, 1990) with enforced parameters of experience also helps to ensure that salient themes are clarified.

The participants' caesarean delivery, whether planned or unplanned must have been 'medically necessary'. To limit the variable of possible added emotional trauma of premature birth, the infant must have been a live birth after 36 weeks gestational age, (Stanton, Lobel, Sears & Deluca, 2002). The birth experience must have been the

women's first caesarean birth, as subsequent caesarean births may provide a different experience for the mother (DiMatteo et al., 1996), and occurred within a period of three years, for reliability and accuracy of retrospective recall (Murphy et al., 2003; VandeVusse, 1999). It would also be preferable that the caesarean section was performed at least six weeks prior to the interview as pain and medication for the surgical procedure could distort perceptions of the experience (Murphy et al., 2003; Smith, 1994, 1999).

Participants were recruited from an article in a community newspaper and an advertisement on a statewide Internet based parenting web-site. Forty-six women responded, and were questioned concerning their suitability regarding the participant criteria. Twenty-two women met the criteria and were posted letters of information, of the 22 women, 19 were available and interviewed within a 6 week time frame.

One woman was excluded from the sample as she revealed during the interview that her caesarean delivery had been under a general anaesthetic and had no recall of the actual birth experience. Thus, the experiences explored in the present study are reflective of 18 women's stories. Demographic details, outside of birth experience, were not collected from the women as the present study was concerned with personal constructs of interpretation of the experience irrespective of variables such as age or socioeconomic status. All of the women in the study were in relationships with the fathers of the children from this birth experience.

### *Data Collection Procedures*

Women were contacted to arrange interview times and location, being either the participant's home or a case study room within the School of Psychology at Edith Cowan University. The 18 interviews were undertaken over 6 weeks with three interviews per week. A timeframe of two hours was allocated for each interview to allow for possible interruptions and development of rapport. Rapport is an important consideration when

interviewing participants about emotive topics (Minichiello, Aroni, Timewell & Alexander, 1995). Techniques that helped to establish rapport include negotiating in general conversation and presenting self as a woman before a researcher (Fontana & Frey, 2003). This was managed by the researcher through engaging in relevant self disclosure as women seek to talk to others who have experienced similar birth experiences (Nelson, 2003). Empathic listening and reflection also helped to maintain rapport during the interview process (Minichiello et al., 1995).

Interviews were audio taped and transcribed verbatim immediately following the interview. The researcher also kept a reflective journal to note prominent thoughts and occurrences outside the actual conversation, such as the overall feelings concerning the interviews or any interesting annotations. A reflective journal also maximises conformability of findings and interpretations (Nagy & Viney, 1994).

### *Ethics*

Ethical issues such as possible emotive reactions to interview content were addressed preceding and following each interview. Participants were repeatedly made aware that they were under no obligation to discuss any issues that caused discomfort and that the interview would be halted at their request at any time. Participants were also reassured that confidentiality would be upheld. Audio recordings were erased following verbatim transcription. Participants' transcripts were allocated a random letter for data analysis. Family members, hospitals and hospital staff were also stated as a generic code (e.g. husband, doctor

### *Data Analysis*

The aim of interpretative phenomenological data analysis is to gain a practical understanding of the narrative through systematic data reorganisation, thus synthesising

the essence of the participant's interpretation of their personal experience (Conroy, 2003; Miles & Huberman, 1994). The present research aimed to extract the super-ordinate themes that encapsulate the birth and post partum experiences and the concepts that determine the logical chain of evidence to arrive at these themes.

Individual interview transcriptions were initially analysed within a network design (Appendix B). This design was utilised as it provides an accessible, organised visual display. A series of nodes represented the themes for the birth and post partum experiences (Miles & Huberman, 1994). Recurring concepts, exemplars and transcription line references were listed below the theme nodes and relationships between the themes, concepts and exemplars are linked with a series of networks and directional arrows. It became apparent whilst extracting the themes and constructs of each interview that there were two distinct superordinate themes, directly related to the mode of delivery.

A thematic conceptual matrix was used for data analysis of the interviews as a whole (Miles & Huberman, 1994). A thematic conceptual matrix is appropriate for exploratory studies and research which is designed to extract the essence of the participants' experiences (Miles & Huberman, 1994). The matrix was organised in three sub sections reflective of the interview schedule; mode of delivery, birth experience and post-partum issues (Appendix C). The mode of delivery sub section looked at context variables describing the physical manner of delivery. The birth experience subsection was categorised into super-ordinate themes and the constructs that synthesised these themes. Psychological variables such as missing time, preoccupation with delivery process and postnatal depression were explored in the post-partum subsection along with care issues, breastfeeding problems and future birth options.

Through analysis of the thematic conceptual matrix, a logical chain of evidence determined the plausibility of each superordinate theme. It was apparent that there were intervening variables that when experienced by the woman could envision her over-riding

feeling about her birth experience. The evidential chain was verified by partitioning each construct within the superordinate themes and building a matrix of percentages of the participants that mentioned each construct within their personal birth and post-partum experience (Miles & Huberman, 1994). Accounting the percentages of occurrence for each construct heightened the credibility of the data as representing the superordinate themes and minimised any researcher bias (Miles & Huberman, 1994).

Rigour was also addressed during analysis through triangulation. Two peers provided independent thematic analysis of the transcripts, blind to the researchers initial analysis. Inter-rater reliability was apparent as the same two superordinate themes were extracted and commonalities of the constructs that combine to make these themes were recognised (Nagy & Viney, 1994).

### Findings and Interpretations

The data consisted of analysis of 18 women's experience. Two sub-samples were evident as determined by mode of delivery, 13 women experienced unplanned caesarean delivery and five women experienced planned caesarean deliveries. Of the 13 unplanned caesarean deliveries, 10 (77%) were after onset of spontaneous labour and three (23%) experienced no labour prior to delivery. There were no accounts of labour experiences within the sub-sample of planned delivery. The caesarean experiences presented in this research were all primipara caesarean deliveries. Five of the women that had primipara unplanned caesarean deliveries had multipara caesarean deliveries within the three year retrospective time-frame although chose to relate only their first experience. In addition, for one woman with an unplanned delivery and for one woman with a planned delivery the caesarean delivery was a multipara birth with a previous vaginal delivery experience.

There were two distinct super-ordinate themes that encapsulate the birth experience of medically necessary caesarean birth, disappointment and acceptance. The theme of

disappointment encapsulated feelings of unfulfilled expectations and a sense of loss of control throughout the birth process. Disappointment was representative of unplanned mode of delivery and related to the onset of spontaneous labour preceding caesarean delivery. The theme of acceptance was constructed by women that learned of the need for caesarean delivery prior to the birth and had time to adjust personal expectations to accommodate surgical birth as an accepted delivery mode.

The superordinate themes from the delivery experience were continuous in the post-partum experience. Post-partum issues were analysed within categories designed to explore psychological variables, issues with care and future birth options. Psychological variables included missing time, preoccupation with birth, detachment to infant immediately following birth, sense of aloneness, physical discomfort and negating disappointment with delivery as the healthy baby. Care issues focussed upon women's perception of hospital care and the importance placed upon family support. The findings for the delivery and post-partum experiences and following interpretations are presented within the superordinate themes, disappointment and acceptance.

### *Disappointment*

For the 13 women that experienced unplanned caesarean deliveries the superordinate theme of disappointment echoed throughout all of the women's stories. The constructs (intervening variables) that predict the over-riding theme of disappointment were a loss of control, for 10 (77%) of the women, over the birth situation and over their bodies ability to birth in the manner that they had expected and the unfulfilling of the delivery expectations, idealised throughout their pregnancies, for 11 (84.6%) of the women.

Women spoke of their delivery expectations as defining the birth process and defining their role as a mother. They felt that not meeting expectations and the loss of control over the delivery as a reflection of their ability to become a mother.

It was like if I can't even do that, if I can't get the birth right,  
how can I be a mother? The birthing part is supposed to be  
natural and the beginning of motherhood, for me anyhow.  
Having babies is what our bodies are designed to do isn't it?

*(Participant I)*

Women that experienced labour spoke on reflection that they were glad that they had the chance to labour and at least 'try' for a vaginal birth, even though six (46%) expressed that they 'failed' to complete the labour experience.

I actually couldn't believe that I had him, as I still had a belly  
on me, and I felt cheated because I didn't push him out. I  
carried him for nine months but I couldn't push him out I felt  
cheated....I remember sitting in the bed listening, straining to  
hear women coming and giving birth and then feeling really  
jealous. And feeling really down and crying.

*(Participant B)*

For women that experienced unplanned deliveries and no labour, they were more likely, in comparison to women that experienced labour, to explain their loss of control in terms of confusion, anger and panic.

I was panicking cause I wasn't sure, at that stage I still didn't  
know what was going to happen in an actual caesarean. I didn't  
want to get cut up. I was pretty angry because no-one had told  
me what was going on. I was very upset about it.

*(Participant G)*



For women that had planned caesarean deliveries, the lack of labour experience was the only construct that they articulated disappointment with and two (40%) of the five women expressed a feeling of being cheated out of this experience.

The superordinate theme of disappointment also resonated through their post-partum experiences, in particular for women that had unplanned caesarean deliveries. The psychological variables of missing time in the post-partum and preoccupation with the birth process were only described by women that had unplanned deliveries. These are constructs that have been associated with traumatic caesarean birth experiences (Ryding et al., 2000). Missing time was mentioned by 10 (77%) women and five of the 10 women described that the feeling of missing time caused them to become preoccupied with the birth process as if they were trying to piece together their experiences.

PND was also experienced predominantly by women that had unplanned births, five women with clinical diagnosis and two women that spoke of scoring high on the Edinburgh Post-natal Depression scale at post-partum health clinic visits, although never returned for further diagnosis or treatment. It has been recognised that not all women that experience PND will present for treatment (Webster et al., 2003). All of the women who experienced PND symptomatology also described the constructs of missing time, detachment from infant, a sense of aloneness, breastfeeding problems and minimal hospital support. Only one of the women that had a planned caesarean was diagnosed with PND. Thus, the overall prevalence of PND and PND symptomatology within the sample of 18 women, was eight women (44.4%), which is approximately three-fold upon the 14% reported in Australian and global research (Gottlieb, Whiffen, Wallace & Mount, 1991; Hauptberger, 1997).

Family support was acknowledged by four (31%) of the women that had unplanned deliveries, as being the most important post-partum construct and describe the family

support as playing a major part within their recovery. It is also of interest to note that women that recall family support did not present any PND diagnosis or symptomatology.

Recent revision of The Diagnostic and Statistical Manual of Mental Disorders 4<sup>th</sup> edition, text revision, (DSM-IV-TR, 2000) has included provisions for traumatic delivery experience to be a precursor for post traumatic stress disorder (PTSD). The linkage between PTSD and delivery experience is an emerging phenomenon and may not be as recognised as PND. It is possible that the diversity of PND symptomatology could lead to misdiagnosis of PND when a diagnosis of PTSD may be more appropriate (Ayers & Pickering, 2001; Reynolds, 1997). Within the sample of 13 women that had unplanned deliveries there were three (23%) women that expressed thoughts and emotions concurrent to PTSD symptomatology, such as intense fear for own life, helplessness, reliving of pain through dreams, severe initial detachment to child, disbelief that birth had taken place and erratic sleep (DSM-IV-TR, 2000). One woman described feeling that she was only going through the motions of caring for her child.

I didn't want to breast feed her and I didn't understand, like  
I knew she was my child, but I thought that there would be  
this emotional sudden connection and there wasn't. This was  
meant to be one of the best experiences of my life and I almost  
don't want to say it, I didn't enjoy it at all. It was all nothingness.

*(Participant A)*

These women also elected planned caesarean deliveries for the birth of their second child, although obstetric advice was given that suggested that vaginal births may be possible. This may emphasise an avoidance of the stimuli associated with their fears, in their cases labour, which is characteristic of women that suffer from PTSD after delivery (Reynolds, 1997). The control present in subsequent planned deliveries is cathartic, and may subdue the initial trauma from the first delivery experience (Reynolds, 1997).

Post-partum care issues focussed upon the role of hospital and family support and included breast-feeding issues. Regardless of mode of delivery, 12 (67%) women reported that they were disappointed with hospital care. The women perceived hospital support to be inadequate and inconsistent and attributed feelings such as detachment from infant, feelings of aloneness and self-blame and physical discomfort as resonating from their post-partum care.

I had this idea that I was going to have a natural birth and was going to see the baby the whole time. But I must have done something wrong as the nurse just took her away from me. They wouldn't tell me what was happening with anything. I don't know how she fed the first day. I didn't like the hospital. I didn't like the staff, I don't think it was personal at all.

*(Participant F)*

For 10 (77%) women that had unplanned deliveries they described feeling that they had expectations of the staff to explain or help them to understand of their need for surgical intervention, which were unfulfilled. Some women spoke of particular nurses or staff that provided fantastic support, still remembered years later, as it was a stark contrast to the care that many women received for the majority of their hospital stay.

Breast-feeding was included in the scope of care issues. It has been suggested that experiences of hospital care within the immediate post-partum period can be influential towards initiation and continuation of breastfeeding (Rowe-Fisher & Murray, 2002). Mode of delivery was a factor relating to whether the women breastfed their infants with over half of the women, seven (54%), that had unplanned deliveries reported difficulties with breastfeeding. Women described that problems with breastfeeding reinforced their overall disappointment with the birth experience, and heightened the feelings of self-blame.

It was an uphill battle the whole way. I didn't have any breaks at all. That first week she screamed the whole time. I was so sure that I would get her on the breast. Nothing else had gone even close to the way that I wanted it to, and now I couldn't get this right either.

*(Participant H)*

In comparison, only one woman that had feeding difficulties after a planned delivery and attributed these problems to perceiving the hospital care as inadequate and unsupportive of her planned caesarean delivery. Hence, she felt uncomfortable asking for help with breastfeeding and chose not to continue with feeding.

The superordinate theme of disappointment following an unplanned caesarean delivery is congruent with findings of previous studies (Cranley et al, 1983; Druik et al., 2000; Murphy et al., 2003). The present study, however, clearly defines the constructs of loss of control and unfulfillment of expectations as suggesting that the delivery experience is interpreted as disappointing for the women. The high incident of variables associated with traumatic deliveries, such as missing time and detachment and the adverse psychological adjustment as evident in the high prevalence of PND are findings unique to the present study and warrant further research with a larger sample.

The concepts that women spoke of such as the lack of ability to be part of decision making processes and the lack of defining oneself through the event are reflective of an overall sense of the birth as a disempowering process (Zimmerman, 1995) for the women. The disempowering processes resonate throughout the post-partum experiences, exemplified by the feelings of self-blame, the perceived lack of control and support and the feelings of vulnerability.

It has been suggested that empowerment can be contextually based (Zimmerman, 1995) and can vary in accordance to one's ever-changing experiences. Personal sense of empowerment can involve fundamental interactive and intrapersonal elements, such as personal perception of an experience that is moderated by the environment (Zimmerman, 1995). Therefore, the finding that overall disappointment with delivery is constructed through women feeling that personal expectations were unfulfilled and there was a loss of control, suggests that moderation of these perceptions following delivery could see less disappointment with, and thus feeling a sense of empowerment about the birth process.

### *Acceptance*

The super-ordinate theme of acceptance of mode of delivery was exemplified by the five women that had experienced planned caesarean delivery. All of the women expressed that they were adequately prepared for the birth. Preparation entailed refining of personal expectations of the birth as being an important part of becoming a mother. The women described feeling that that the delivery was simply a vehicle to deliver their healthy baby.

It's not about me, I am his mother, I carried him for nine months. As long as he arrives safely, does it matter how? No.

*(Participant R)*

Preparation also included education concerning the actual physical events that would occur during the surgical procedure. For four (80%) of the women the ability to prepare for the birth helped them to retain a degree of control of the situation. The women accepted the rationale that planned caesarean delivery was the safest and healthiest mode of delivery for themselves or their infant. As the five women in this sub-sample had learned of the need for a caesarean delivery at least 10 weeks prior to the birth, the

emotive reaction that was present when they initially learned of the need to plan a caesarean delivery had been replaced with acceptance prior to the birth.

Well I was of course going to have a drug free natural birth,  
and completely skipped the caesarean sections in the books...

At 20 weeks after my OB [Obstetrician] told me about my pelvic problems, I promptly got them out and read them! I was a little worried ....but I trusted my doctor and was happy to trust his experience and take his advice as to what was the best way for me, and my baby to give birth.

*(Participant Q)*

For women that experienced planned caesarean deliveries the delivery brought a sense of relief knowing that they would soon meet their healthy infant.

In comparison only three (23%) of the 13 women that experienced unplanned caesareans felt relief following the delivery. Relief after the birth was related to a feeling that the disappointing elements of the birth were negated by the health of the baby as described by eight (44%) of women from the overall sample of 18 women. All of the women that had planned caesarean deliveries acknowledged these feelings, and of women that had unplanned deliveries only the three women that spoke of relief spoke of having feels of disappointment negated by the health of the baby. All of the women that had planned deliveries also spoke of feeling that families and partners were supportive of their delivery.

The majority of women, 16 (89%), indicated that they accept that future births would be planned caesarean deliveries. Whilst many women mused that they would like to experience a vaginal birth, they conceded that their past experience, especially for those women that had unplanned deliveries, determined that planned caesarean deliveries would be their preferred option. Women spoke of not wanting to feel like they had failed if a

vaginal birth after caesarean (VBAC) was not possible, and not wanting to place unobtainable expectations on themselves. Women also suggested that they would gain control over the birth experience if they could choose the day and mode of delivery.

The appraisal of planned deliveries as more positive than unplanned deliveries is consistent with previous research (Cranley et al, 1983; Druik et al., 2000). The present research provides further insights into why women accept planned deliveries. The finding that preparation for the delivery includes moderating expectations in regard to self concepts of motherhood has implications for general preparation for birth, regardless of mode of delivery.

Women who expressed acceptance of the planned delivery were empowered by processes within their birth experience. Lapeirre, Perrault and Goulet (1995) suggest that women are empowered if they have the ability to fulfil physical, emotional and psychosocial needs. Through the control that the women had over the preparation for the birth and the adjusting of their self-expectations of motherhood women satisfied their delivery needs.

### Implications

The present study exemplifies the importance of women's interpretation of their delivery and the effect that context of delivery has upon interpretation. The relevance of the post-partum period for reinforcing delivery experience was also apparent. The pertinence of delivery context and post-partum experience is also evident with the high incidence of traumatic deliveries (suggesting PTSD symptomatology) and cases of PND within the sub-sample of women with unplanned deliveries.

The finding that minimal family support could be linked to PND and reinforce traumatic birth interpretation, has implications for post partum care. Creedy, Shochet and Horsfall (2000) showed that family support could buffer against interpreting delivery in a more traumatic way, and the findings here reinforce this view. It has also been suggested

that familial and social support can increase intrapersonal and interactional processes such as self-control and decision-making abilities and thus increase personal feelings of empowerment (Kovach, Becker & Worley, 2004; Zimmerman, 1995). Thus, finding ways to increase empowering process through support networks in the post partum period should help to lessen the risk for women to interpret delivery as traumatic and the onset of PND.

Women seek to find occasion to discuss their birth experiences (Cooke & Stacey, 2003; Gamble & Creedy, 2004). Post-partum care needs to include outlets for active discussion and reflection for women after emotive and/or traumatic birth experiences. Group programs based upon expression of personal narratives and finding a sense of empowerment through exploring women's stories such as the Listening Partners Program (Bond, Belenky & Weinstock, 2000), have been shown to be a place of support and help women to overcome emotive experiences.

The understanding that unplanned caesarean delivery is more traumatic emotionally, and psychologically than planned caesarean delivery, suggests that actively preparing and educating women for caesarean delivery is advisable, regardless of expected mode of delivery. Preparation for delivery also needs to address that birth expectations cannot be static and motherhood is not definable by mode of delivery. Although accessing a small sample size suggests that the results will not be generalised across the wider population, it could be suggested that the themes and concepts that are generated by this research could be applicable to many women who experience caesarean deliveries.

### Limitations

The number of participants that were interviewed was acceptable within an interpretive paradigm and the saturation of the themes from data collected suggests that these stories were representative of the women's experiences. However, it would have



been desirable to interview more participants that had planned caesarean deliveries. It was felt that this group of women were under-represented in comparison to women that experienced unplanned deliveries.

It seems that the constructs that were part of the unplanned caesarean experience provide motivation for the women to seek out forums to express their feelings. This may suggest that women that actively seek to relate their negative and disappointing experiences are at an extreme end in the birth experience continuum. As women stated that they felt reflection about their delivery at the time of the interview was cathartic, a follow up interview would have been beneficial to assess if this feeling was maintained over time.

The present study had specific participant criteria and boundaries for the context of the delivery. However, less specific criteria and a more widely disbursed sample, including single women, premature births and multiparous caesarean deliveries may bring multiple perspectives and different array of themes and constructs that surround the caesarean delivery experience.

### Conclusions

Women's interpretation of the experience of a medically necessary caesarean delivery is a product of context, the congruence of the context to pre-delivery expectations and post-partum events. The importance of support and care in the post-partum period is seen as vital for women's later recollections of their delivery experiences. The present research builds upon previous research findings and provides a Western Australian perspective. The high incidence of traumatic delivery experience and prevalence of PND provide suggest that further exploration into women's interpretation of delivery experiences and perception of post partum care is vital.

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## Appendix A

### Interview Schedule

The schedule has three sub sections; Prebirth, Birth and Post-birth.

Each subsection has questions related to context, thoughts and feelings. The questions are provided as general markers and guides to explore the topic.

#### Prebirth

This section explores the reason for C-section

- ~ Firstly can you describe your how far along in the pregnancy you were?
- ~ How did you think that your pregnancy/ labour was commencing?
- ~ How did you feel about your pregnancy/ labour?
- ~ When did it first become apparent that a c-section would be needed for the birth of your baby? And the medical reason?
- ~ What was the time frame between knowing that a c-section would be the birth procedure and the actual c-section?
- ~ Do you remember you initial thoughts when you were told that a c-section would be necessary for your baby to be born?
- ~ How did you feel about the decision that was made that your baby would be born via c-section?
- ~ Did you have any expectations pre-birth about how the birth of your baby would happen?

If before labour; did you understand the reasons for the c-section? Do you think that having a few days notice changed how you viewed the birth procedure?

- ~ Who told you of the need for the c-section, your OB?
- ~ How was the necessity for a c-section described to you?
- ~ Was your husband / support person with you when you were told you would need a c-section?
- ~ Did your husband /support person express any views on the need for a c-section?
- ~ Do you know how your husband / support person felt and their concerns ?
- ~ Did you have any concerns for your safety?
- ~ Did you have any concerns for the safety/healthy of the baby?

#### Birth

- ~ Was your husband / support person present at the birth?
- ~ If the C-section became necessary during labour, was there a wait before the surgery  
Or were you taken immediately into surgery?
- ~ Did you get to see or hold your baby immediately after the birth?

- ~ Was your baby brought to you in recovery or later in your room?
- ~ Do you remember the feelings you experienced as you were taken into surgery for your baby to be delivered?
- ~ Describe the feelings you had when your baby was delivered

### **Post birth**

- ~ Did you get to see or hold your baby immediately after the birth?
- ~ Was your baby brought to you in recovery or later in your room?
- ~ Did your husband / support person (if present at birth) go with you to recovery or to the nursery with the baby?
- ~ How long was your hospital stay?
- ~ What were families' members reactions like toward the c-section?
- ~ Do you think that having the c-section affected your post partum experiences?
- ~ Did you have any post-partum complications?
- ~ Describe your first few days and how you felt coping with a new baby?

**Can you summarise or explain to me the most prominent feelings and emotions that you recall from the entire experience.**

For example ~ Where Expectations met?

- ~ Do you have regrets?
- ~ Do you wish that the birth was different?
- ~ hindsight?

### **If not mentioned**

If you feel comfortable I would just like to ask some questions about PND?

If completed EPNDS?

Experiences?

Feel related to delivery?



## Appendix B

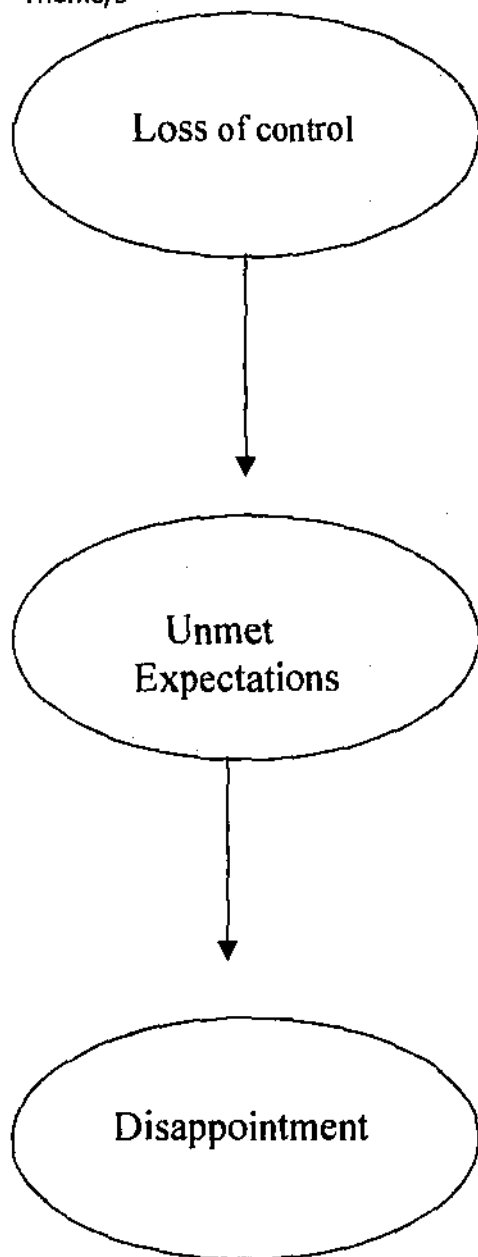
PARTICIPANT ~ I

Birth Context

Unplanned C/s

Labour, failure to progress

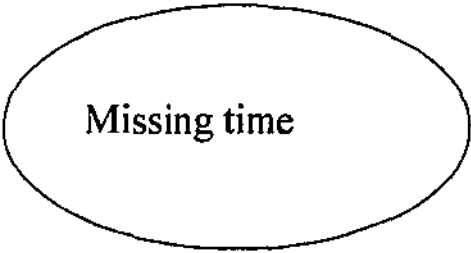
Theme/s



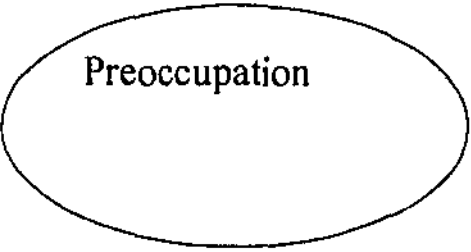
Concepts/Exemplars	Line #/Quotes
Body not performing as Expected	#152 Its.....
Womens Roles	#186 to become a Mother.....
Planned	#125 my birth plan..
Role to motherhood	#296 It would be...
Societal views	#322 assumed that.....
Letting down	# 412 my husband ..... .....
Worst experience of life	# 439 It is not.....
Failure as disappointed	#399 why is it....

## Post Partum Experience

## Themes



Missing time



Preoccupation

Concepts/Exemplars	Line #/Quotes
Blurred /Surreal	#254 I felt as if I was not.. # 269 wasn't really there
Lost memories	# 341 not know....
Detachment	# 362 was he mine..
Details	#326 I wanted it Explained.....
Obsessing	#458 If I knew I could relive.....
Dreams	# 496 Shutting my Eyes.....
Feeding problems	#421 wanted to...

## Further observations or experiences

Unprepared-though felt ready for motherhood, didn't realise how emotive/draining c/s could be

Ashamed not perceived 'natural'

PND -diagnosis 4 months

Lost sleep, avoidance of wanting labour /failure for 2<sup>nd</sup> birth (poss PTSD)

Fear for life and babies

Went on to 2<sup>nd</sup> planned c/s

Part	PI	Birth Type			Superordinate Themes									
		unpl	Labour	No-Labour	loss co	fear	anger	failure	un ex	pre/ex	Acceptance control	nerve	cheated	general relief
A		*		*	*	*	*		*					
B		*	*		*			*	*					
C		*	*		*				*					
D		*	*		*			*	*					
E		*	*		*			*	*					
F		*	*		*	*pain			*					
G		*		*	*	*panic	*		*					
H		*	*		*			*	*					
I		*	*		*	*		*	*					
J		*		*	*			*	*					
K		*	*		*				*					*
L		*	*		*				*					*
M		*	*											*
%			77%	23%	77%	30.70%	15%	46%	85%					23%
N	*			*						*	*			*
O	*			*						*	*	*		*
P	*			*						*			*	*
Q	*			*						*	*			*
R	*			*						*	*	*	*	
%										100%	80%	40%	40%	80%