

**An exploratory study of mothers' perceptions and experiences of
an unplanned Caesarean section**

Samantha Lynne Roux

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North-West University

Faculty of Health Sciences

Department of Psychology

School of Psycho-Social Behavioural Sciences

Potchefstroom Campus

Potchefstroom

Supervisor: Prof. E. van Rensburg

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ABSTRACT

Objective The present study aimed to explore women's perceptions and experiences of childbirth by unplanned Caesarean section. **Background** New motherhood is characterised as a profound change, and research suggests that the psychological effects of childbirth can be significant and far-reaching for some women. The processes occurring during a traumatic birth experience could affect a woman's emotional and psychological state, and she may experience considerable adjustment difficulties in adapting to unfulfilled expectations of delivering her baby naturally. **Methods** In-depth interviews explored 10 women's lived experiences of childbirth, after which thematic content analysis was used to synthesise data. The elements of phenomenological theory served as a broad framework for the structuring, organizing and categorizing of data, with interpretation aimed at gaining a greater understanding of women's internalised childbirth accounts. **Findings** Women described their contact with medical personnel, as well as the physical, environmental, and emotional aspects of their unplanned Caesarean sections, as distressing and traumatic. A sense of loss of control was the most significant contributor to women's negative childbirth experiences. Feelings of failure and disappointment were primarily related to unmet expectations and a lack of preparedness. Negative experiences were mediated by attentive caregiving, inclusion in decision-making, and support from loved ones.

Keywords: failed natural birth; interpretive phenomenology; mothers' experiences; mothers' perceptions; qualitative research; unplanned Caesarean section

INTRODUCTION

Pregnancy is an important life experience in a woman's psychosocial and psychological development (Bryanton et al., 2008; Hall and Taylor, 2004). Childbirth is viewed as a journey, shared between mother and baby. The memory and experience of it, vivid and intense, will stay with a woman throughout her life (Lothian, 2000; Nystedt et al., 2008). Despite medical advances, many women still hold strong views about the importance of actively participating and working with their bodies to achieve a vaginal birth. Women consider vaginal birth to enhance the health and well-being of the mother, promote maternal-infant connection and bonding, and ease the transition to motherhood (Fenwick et al., 2007; Parratt, 2002). However, many births culminate in a Caesarean delivery for various reasons, including health reasons and complications during birth (Kealy et al., 2010). Despite consistently advancing understandings in psychology and of patient care, a failed natural birth is a psychological, psychosocial, and existential challenge for women. In some instances, this can have significant and far-reaching consequences for their psychological well-being (Fenwick et al., 2007; Ryding et al., 1998; Porreco and Thorp, 1996).

A woman's experience of childbirth and her perceptions of the event can be influenced by multiple, complex factors. These can include her cultural beliefs, her anticipations of the birth, possible traumatic events in her life, available social support, and her personal sense of control. Furthermore, a woman's attitude towards birth, her expectations, and her personal and subjective attributed meaning to giving birth could affect her feelings of satisfaction, strength, esteem, and achievement (Gibbons and Thomson, 2001; Simkin, 1991).

Women often attribute a Caesarean delivery to their own perceived inadequacies (Peart, 2004). Negative perceptions of the Caesarean delivery may lower women's self-esteem, and many consider themselves incompetent after a failed vaginal delivery. This leaves them with a sense of failure, loss of control and disappointment, and causes a distrust in personal

abilities as childbearing women (Berg and Dahlberg, 1998; Boyce and Todd, 1992; Lobel and DeLuca, 2007).

Complicated labour with unplanned operative delivery is also described as having a negative influence on the transition to motherhood (Herishanu-Gilutz et al., 2009; Nelson, 2003; Olin and Faxelid, 2003). As women strive to incorporate their undesired delivery experiences into their self-system, they may experience difficulties in trying to form an identity as a mother (Weiss et al., 2009; Berg and Dahlberg, 1998). Nystedt et al. (2008) interpreted these difficulties to be like 'fumbling in the dark'. Subsequently, mothers may have more ambiguous feelings toward their babies (Yokote, 2008), exhibit poorer parenting behaviours (Lobel and DeLuca, 2007), experience guilt (Berg and Dahlberg, 1998), and feel detached from their infants (Ryding et al., 1998).

Traumatic delivery experiences have been recognized as a potential trigger for the development of post-traumatic stress disorder during the postpartum period, when intrusive thoughts, images and memories may be related to the birth and can generate nervous tension (Alder et al., 2006; Ryding et al., 1998). Studies suggest that post-traumatic stress is a much more common psychological response to an unanticipated Caesarean section than expected (Soet et al., 2003). When women learn that they are going to have a Caesarean section, their feelings of confidence and security quickly change to ones of stress, fear and anxiety (Ryding et al., 1998; Berg and Dahlberg, 1998). A fear of injuries that their baby might sustain, fear for their own lives, and fear of not waking up from the general anaesthesia (Ryding et al., 1998) may cause women to experience increased traumatic stress responses. These reactions may include panic, shock, dissociation, and feelings of being overwhelmed and of giving up (Ayers, 2007; Yokote, 2008). The risk of a traumatic reaction increases when women's perceptions of an emergency Caesarean include disappointment, sadness, anger, and guilt (Good Mojab, 2009; Boyce and Todd, 1992).

Literature also controversially links obstetric factors, including delivery-related complications such as an emergency Caesarean section, with post-partum depression (Lobel and DeLuca, 2007; Robertson et al., 2004; Torkan et al., 2007). Australian researchers concluded that 46% of the women in their study who had an emergency Caesarean section were more than six times more likely to develop symptoms of depression than women who had spontaneous vaginal or forceps deliveries (Boyce and Todd, 1992). Potential risk factors of a negative birth experience include disruption of birth plans, dissatisfaction with the birth process, unmet expectations, low self-esteem, and poor social support (Benoit et al., 2007; Creedy et al., 2000). The occurrence of depressive illness following childbirth can be detrimental to the mother, her marital relationship, and her relationship with her child (Robertson et al., 2004).

Research shows that some women experience significant long-term adverse reactions to their Caesarean deliveries. Rijnders et al. (2008) found that although many women recalled their experience as a positive event in the long term, an unplanned caesarean delivery significantly increased the risk of negative recall. Several years after giving birth, mothers who delivered by Caesarean section may express dominant feelings of fear and anxiety about their experience. Common factors of a negative long-term appraisal of birth include feeling that the baby's life had been in danger, negative perceptions of the staff, and major health problems since the birth (Baston et al., 2008; Jolly et al., 1999; Weiss et al., 2009).

Research, especially recent research, on the experiences of women who most wanted to, but were unable to deliver their babies naturally is relatively rare. This is surprising given the diverse implications of such disappointment for the mother's emotional well-being, as well as for her feelings toward her new baby (Parratt, 2002). Furthermore, there is no existing research on South African women's experiences of a failed vaginal birth. Neither does a phenomenological orientation seem to have been applied to local contexts in determining how women experience an unplanned Caesarean section. This study therefore aimed at

exploring and understanding the subjective experiences and perceptions of South African women who had delivered their babies by an unplanned Caesarean section.

RESEARCH DESIGN

An exploratory, descriptive, qualitative research design was used to explore and describe women's subjective experiences of an unplanned Caesarean section. Qualitative research examines the lived experience in an effort to describe, explain, understand, and give meaning to peoples' experiences, behaviours, interactions and social contexts (Fossey et al., 2002; Strauss and Corbin, 1998). Within qualitative research, phenomenology refers to the individual's personal construction of the meaning of a phenomenon (Mertens, 2009). Original data is comprised of 'naive' descriptions obtained through open-ended questions and dialogue, and the researcher describes the structure of the experience based on reflection and interpretation of the research participant's story (Moustakas, 1994). Such an approach places this study within the interpretive phenomenological perspective. The researcher explored in detail how mothers made sense of their unplanned Caesarean experiences with the intention of understanding their meaning, while simultaneously interpreting how themes of meaning are structured.

RESEARCH METHODS

The research began with ensuring ethically sound research, followed by data collection and analysis. Throughout the study, trustworthiness of the research findings was ensured.

Ethical considerations

Ethical issues and standards were critically considered in this research project. In accordance with the ethical rules of conduct for practitioners registered under the Health Professions Act, 1974, as stipulated in the HPCSA Ethical Code of Professional Conduct (2004), several measures were taken to ensure the ethicality of this research. Firstly, the research protocol was approved by the Ethics Committee of the North-West University

(Potchefstroom Campus: NWU-00056-09-S1). Thereafter, prospective participants were informed of the background to the study and the voluntary nature of participation in the study. Interviews proceeded once participants had given verbal and written consent. The researcher was fully aware of the sensitive and emotional nature of exploratory inquiry, and the rights and needs of the individual were therefore considered at all times. Furthermore, the participants were assured of confidentiality. Finally, participants were debriefed at the resolution of the interview process to resolve any questions, unease or queries.

Population and sampling

Phenomenology uses purposive, non-probability sampling procedures, where participants are included because they have a specific knowledge of the phenomena (Baker et al., 1992). For the purposes of this study, an *unplanned Caesarean section* referred to a surgical, Caesarean delivery, despite the mother's desire to deliver her baby naturally. Such a delivery may have occurred after labour had begun due to unexpected maternal or foetal conditions, or prior to labour, as is the case in an emergency Caesarean delivery. Thus, in this study, the population of interest comprised mothers who had wanted to deliver their babies naturally, but who had instead had to deliver their babies by Caesarean section. Within the population of interest, participants had to comply with the following criteria:

- Married women
- Mothers aged 25-30 years
- It was the birth of each woman's first-born child that culminated in a Caesarean delivery
- A period of 2 to 4 years had elapsed since each woman's unplanned Caesarean delivery
- Caucasian women: Cultural beliefs about and values associated with childbearing touch all aspects of social life in any given culture. Such beliefs and values could

lend different perspectives to the meaning of childbirth to the childbearing woman (Callister, 2006).

- No previous miscarriages had been experienced

Selection of participants included snowball sampling, as discussed by Babbie (2007), where women nominated acquaintances whom they thought may be willing to participate in the research. The sample comprised ten women, with a mean age of 28 years, who volunteered for in-depth phenomenological semi-structured interviews. Interviews were not limited to a certain number, but continued until data saturation had taken place in order to deepen, enrich and complete categories, themes and concepts (Brink and Wood, 2001).

Data collection

Various aspects were explored in in-depth phenomenological interviews, allowing the researcher to probe certain aspects offered by participants in order to understand and explore their contributions in as much depth as possible. A semi-structured, open-ended approach allowed for the exploration of relevant opinions, perceptions, feelings, and comments in relation to the women's experiences.

Data analysis

Thematic content analysis allows for detailed analysis of data (Nystedt et al., 2008). When it comes to analysis, phenomenological researchers engage in active and sustained reflection as they 'dwell' with the data and interrogate the content. By applying the analytical method as suggested by Wertz (1983) and Giorgi (1985), analysis involved systematic readings of the transcripts and field notes by first dwelling on the phenomenon (through empathetic immersion and reflection), and then describing emergent psychological structures (i.e., constituents and recurrent themes). Analysis continued with a cross-category search to identify recurring regularities expressed as themes that were seen at an interpretive level as underlying threads of meaning running through condensed meaning units, codes, or

categories (Graneheim and Lundman, 2004). Themes were then categorized so that data could be synthesized and comparisons could take place.

Measures to ensure trustworthiness

To ensure validity of results, Guba's model (1985) of trustworthiness of qualitative research was applied to this study (Lincoln and Guba, 1985). The model identifies four aspects of enhanced trustworthiness of a study, namely, credibility, transferability, confirmability, and dependability.

To enhance credibility, the researcher engaged in active and sustained reflection during data interpretation to ensure quality, and to highlight the complexity of participants' experiences (Marshall and Rossman, 1995). The researcher aimed to suspend previous assumptions in order to be open to the phenomenon as it appeared, and to generate a sense of reality and a personal recognition of the phenomenon through precise and rich description. This refers to the extent to which the findings are a function solely of the research participants and conditions of the research, with no biases, motivations and researchers' perceptions (Krefting, 1991).

Transferability was achieved through thorough description of the research context and the assumptions that were central to the research. The criteria applied were made explicit, according to the purpose and orientation of the study (Patton, 2002).

To ensure confirmability in this study, the researcher and an external auditor reached agreement that the findings, conclusions and recommendations made by the researcher were supported by the data and that the researcher's interpretation of the data was meaningful and relevant.

Dependability was achieved through clear and thorough description of methods used in gathering, analysis and interpretation of data, as well as in the precise and comprehensive reporting of data. Documentation was such that other researchers would be able to follow the investigative process and reach similar conclusions given the researcher's data, perspective and situation (Marshall and Rossman, 1995).

FINDINGS

Thematic content analysis gave rise to the identification of the themes relevant to exploring women's experiences of their unplanned Caesarean sections. These themes have been categorised for identification and are presented in Table 1.

[Insert Table 1 here]

The physical experience

Labour was acknowledged as primarily 'a very physical process' (Mom 2). Women described their physical experience in relation to pain, exhaustion, the effect of medication, and a loss of privacy.

(a) The experience of pain

Eight of the women had experienced a trial of labour before a Caesarean section became necessary. The initial periods of labour were experienced as calm and bearable. However, due to complications or physical limitations, labour later became prolonged and difficult. In these cases, women described the pain as 'just unbelievable, it was just incredible' (Mom 10). During the actual Caesarean procedure, anaesthesia numbed the pain, but once the medication had worn off post-Caesarean, mothers described a period of intense 'physical trauma' (Mom 7). One woman described how she had 'never experienced such a blocked nose before' (Mom 6), while another reported how she had 'had pains in my shoulders, I was tender, I was bruised, I felt like I couldn't breathe properly' (Mom 8). Several mothers also

experienced 'breasts [that] were so sore' (Mom 7). For some women, these symptoms persisted for up to six weeks after the birth and were identified as significant contributors to a negative Caesarean experience.

(b) The experience of exhaustion

The birth period was considered a physically gruelling experience for several reasons. For five of the women, a lengthy trial of labour left them 'tired [and] so exhausted' (Mom 6). For all the women, heightened somatic stress reactions in response to having an unplanned Caesarean section, together with the pain and fatigue that resulted from having a major operation, contributed to a strenuous and wearing labour experience: 'The whole thing was so draining ... By the end I was finished, mentally and physically' (Mom 4).

For all the women, the prolonged and painful recovery period post-Caesarean was extremely taxing, primarily because they 'almost didn't even have the energy to care' (Mom 4). Physical limitations included diminished energy levels and a reduced capacity to perform several self-care and caregiving tasks. This period was frustrating for mothers as they struggled to care for their newborns. As Mom 7 said, 'Walking her, carrying her, moving, sitting, coughing, sneezing, laughing, was all stuff that I couldn't do.' Consequently, some mothers were left with a feeling of emptiness at not having given birth naturally and not taking part in caring for their baby immediately after the delivery. Furthermore, physical tenderness and overwhelming fatigue were perceived to have compromised initial mother-infant bonding.

(c) The effect of medication

For five of the women, the effect of medication had a profoundly negative impact on the birth experience. For three of the mothers, adverse physical reactions to pain relief included nausea and vomiting: '[The medication] made me feel terrible. I think that added to the whole

trauma of it, because I was just feeling so bad. It was nausea, I was vomiting ... It was horrible' (Mom 2).

The desire to have a natural birth was often associated with a conscious and active process of birthing. Nine of the mothers aspired to work with their bodies to deliver their babies themselves. For four of the women however, the sedating effects of the medication resulted in a passive labour and birth process. One woman described how the medication had made her feel 'so spaced out ... I lost concept of time, like three minutes felt like three hours, and three hours felt like three minutes ... I was tingling, I was hot and cold, I was numb, just totally spacey' (Mom 3). Furthermore, anaesthesia and medication numbed all physical sensations of birth, and mothers felt detached from their bodies: 'It almost wasn't real ... You're not involved at all. You can't choose ... You are just sitting there and your baby is being born for you. You aren't doing a thing. The only thing that I had to do was stay awake' (Mom 7). The passivity of a Caesarean section left mothers feeling disengaged and removed from the birth of their child, and that the active and physical experience of childbirth had been lost.

(d) Loss of privacy

In a Caesarean, as in any other form of surgery, body boundaries are violated and this can be a difficult experience for some women. During preparation for surgery, mothers recounted how 'you just lie there like a turkey being basted' (Mom 7). This left them feeling 'vulnerable and very exposed' (Mom 4). Surgery itself was detailed as a procedure whereby doctors '[cut] you up like they're going to serve you for dinner' (Mom 3). Thus, women's privacy was compromised by their dependence on physicians, a sense of loss of autonomy, feelings of depersonalization, and perceptions of insensitive physical invasion.

The experience of the environment

Environmental factors have the potential to affect the subjective experiences of an event. Women experienced the birth environment as 'all white and clinical' (Mom 7). Women described their experiences in relation to the clinical surroundings, activity, and other women.

(a) The experience of clinical surroundings

For four of the women, the cold and unreceptive hospital settings contributed to a negative birth experience. This was primarily because they had perceived the surroundings as an unwelcoming and uncomfortable environment in which to bring a baby: '[The hospital] is so unfriendly for a baby, [it] is just so white and sterile' (Mom 7). One woman explained that 'It must be so traumatic for him as well, coming into this world in a very clinical, sterile setting with harsh lights and all of those things' (Mom 4). Women were left feeling dissatisfied as they perceived the clinical and medical experience, typical of a hospital setting, to be less personal and intimate than they had wanted and expected.

(b) The experience of activity

Once the decision to perform an emergency Caesarean section had been made, six of the women described the ensuing events as 'complete and utter chaos' (Mom 8). In the short time period that followed, women were exposed to several different members of the medical staff and, with everything happening so quickly around them, they described their surroundings as 'a bit panicky' (Mom 2). This contributed to a sense of bewilderment: 'It just felt like everything was just going so fast, all rushing past me so quickly. And there was nothing I could do to stop it. I was just lost in it' (Mom 10).

Perceptions of pandemonium were further compounded by a sense of unpreparedness. Consequently, in the commotion that accompanied a Caesarean delivery, women were left feeling disorientated, uncertain and insecure: 'Nurses would rush past me and they wouldn't

tell me where I was or where they were taking me ... I mean, they probably thought that I was supposed to know but I didn't' (Mom 6). Mom 7 explained that: 'It's so confusing, you don't know if this is normal, or if this should be happening. You wonder if this happened to the woman next door for instance.' The speed of events and the perceived disorder around them was distressing and anxiety-provoking for mothers as their expectations of predictability and controllability were challenged. This left them feeling unsettled, helpless, and vulnerable in their confusion.

(c) The experience of other women

Mothers compared themselves to other women in terms of their abilities as mothers and women. For most women, natural birth was perceived as a rite of passage to motherhood; something that women's 'bodies were designed for' (Mom 1). After a Caesarean section, mothers expressed feelings of being 'inadequate' (Mom 6) and of 'not being as good' (Mom 7) as other mothers who had been able to deliver their babies naturally. Furthermore, a failed natural birth was perceived by some mothers to reflect their failure as a woman. As Mom 3 said, 'Women have been able to do it for centuries, why hadn't I been able to do it?' Thus, women's self-confidence and self-esteem were threatened as a sense of failure, self-blame and self-doubt left them feeling both inadequate about their own abilities and inferior to other women.

(d) Support

A husband's presence was of remarkable significance in women's labour and birth experiences. Firstly, the shared experience of their babies' births represented an intimate connection between husbands and wives, and it 'was exciting going through it together' (Mom 3). Furthermore, it was symbolic of the transformation into a family unit. These women described that 'as a family, [it was] the ultimate connection' (Mom 1). Secondly, affection and support from their husbands was reassuring to women. Husbands were identified as a considerable source of comfort, providing women with a sense of familiarity in the unknown,

anxiety-provoking Caesarean environment: 'I don't know how I would've done it without him. Having the person you love and trust the most there, it kind of eases all the rest of it' (Mom 2). Family members, friends, and caregivers were regarded by mothers as other significant sources of environmental support. They served to reassure mothers, assist them in self-care tasks, and calm their anxieties. Difficult feelings and physical limitations that followed the Caesarean section were thus experienced as more manageable with the care and assistance of others.

The experience of medical staff

The perceived support received by staff was an important contributor to the experience of a Caesarean section. Mothers' experiences of the quality of care by hospital staff were described in relation to factors relating to staff members' personalities, factors relating to staff members' behaviour, and the role of communication.

(a) Experiences related to aspects of staff members' personalities

Characteristic qualities and attributes of doctors and staff played a significant role in reducing the stress experienced by mothers during birth. A soothing personality style was a source of reassurance and comfort for mothers, and helped to lower anxious responses. As Mom 6 described, '[The doctor] is a very calm sort of person. You know, the way he talks to you, he just has a way of making you feel at ease.' Furthermore, throughout the entire birth process, the level of care received from staff was perceived to be of significant value. Sympathetic, attentive and supportive assistance from staff, especially during the initial period after the surgery, played a significant role in mothers' experiences of the Caesarean delivery. Encouraging, placating and accommodating staff members were 'wonderful in helping to accept what was happening' (Mom 3). Their support helped mothers to feel 'a lot more comfortable, it helps to take off the edge, and it just made it so much easier' (Mom 8).

(b) Experiences related to aspects of staff members' behaviour

Mothers' emotional reactions during labour and surgery were susceptible to the influence of medical staff's conduct. Six of the women described staff's reactions and management of the Caesarean section as frantic. They became concerned in response to the atmosphere of alarm, with their distress pertaining to a sense of emergency: 'I started freaking out ... Going into theatre, nothing was controlled, everyone seemed to be in a panic. And I mean, you look to the doctors to be calm. And she was totally composed, but you could see the panic in her face' (Mom 8). Mom 2 further explained that: 'I heard them shouting to each other to hurry up, so it was a bit panicky, which made me a bit panicky ... It was very frightening.' Thus, as mothers struggled to adjust to the frantic rush of preoperative procedures, staff members' frenzied management of the situation increased their levels of anxiety, and contributed to negative and traumatic perceptions of the birth and operative processes.

(c) The role of communication

The extent to which mothers felt they were involved in decision-making determined their feelings of confidence and satisfaction by affecting their perceived levels of involvement. Mothers who felt that they had played a role in decision-making felt respected and valued, and were more accepting of consequent events. Conversely, mothers who felt that they had been ignored or intimidated in decision-making described feeling undermined and pressurized by staff and doctors: 'I also think society places a lot of pressure on first time moms in terms of "We're medical professionals so we know what we're doing" ... They don't take your feelings or emotions into consideration. Personally, I don't think that medical professionals consider all sides of the coin. They are just very pro-Caesar today, because it's easier and more money for them' (Mom 7).

Being informed and aware of what was happening during labour and birth was an important variable in determining how women experienced the birth: 'My [gynaecologist] talked me through it and, before he did anything, he told me what he was going to do, and [he] did

everything so I could see it. Even in surgery, I could see all the instruments, which helped. I guess it kind of helped to connect me with my body a bit' (Mom 1). Adequate communication by staff thus contributed to a sense of inclusion and respect in the process. On the other hand, some women were critical of inadequate communication during the labour period, as it was perceived as contributing to a sense of insecurity and uncertainty. A sense of disregard by staff was accompanied by feelings of anxiety and uncertainty as staff directed the experience. As Mom 4 said, 'I was feeling very vulnerable and very exposed ... They don't communicate with you at all. So my biggest thing was just that I could feel them working on me and I could feel that things were happening, but no one was telling me what they were doing, what was going on, all that.'

Post-Caesarean, women spoke of the need to have their questions answered, and to be able to talk about their Caesarean section with caregivers to try to appreciate why it happened. Understanding gained through such discussion determined the level of acceptance of the procedure, and the degree of satisfaction with the birth experience.

The emotional experience

Mothers expressed feelings of high emotional turmoil in relation to their unplanned Caesarean birth. The delivery experience was described as 'an emotional rollercoaster' (Mom 9), and was associated with emotions such as frustration, anxiety, disappointment, and anticipation. Negative post-Caesarean emotional responses included acute trauma symptoms, post-partum 'baby blues' or depressive mood disturbance, and grief.

(a) Frustration

For five of the women, the birth experience was recalled with a sense of anger. Feelings of resentment were directed primarily at staff and doctors, because of the perceived manner in which they had been treated. They complained that staff's management and handling of them had 'made the experience more stressful than it should've been' (Mom 4). Mothers 'just

didn't realise, or think to moan at those people' (Mom 6), and the resultant feelings of intimidation, disrespect, and disregard were accompanied by a sense of regret and an internalized and self-directed anger for their acquiescence: 'Afterwards, when I thought about it ... I just think, how stupid was I to actually believe their nonsense. I know they are experts and they are medically trained, and I know I should trust them, but it almost felt as if she was bullying me' (Mom 7).

Furthermore, the loss of independence and self-efficacy during the recovery period was described by women as a frustrating experience. As Mom 3 said, 'Then the recovery took the full six weeks ... I had to move slowly and I couldn't really drive properly ... I had to be careful with what I carried and how I moved, it was a pain. That was one of the main reasons I wanted a natural birth; so that I could be independent as fast as possible.' Thus, feelings of frustration were described in response to a compromised sense of autonomy and control, both during the birth and post-Caesarean. This was negatively attributed to doctors' assumption of power, as well as mother's own feelings of submission.

(b) Anxiety

The distress experienced by all of the mothers during the Caesarean delivery was primarily expressed as feelings of anxiety. The speed and emergency of the procedure is 'so quick, and everything is happening so fast that there's no time to process it and think about it' (Mom 2). This contributed to a sense of bewilderment and angst because 'it is just chaos. And when there is so much chaos, you automatically go into panic mode. You can't stay calm and you can't relax' (Mom 7). For seven of the mothers, the uncertainty that they experienced included significant concern about whether their babies were 'still going to live through all of this' (Mom 9). Anxiety-provoking aspects of the unplanned Caesarean section thus included the perception of procedural events as frantic and chaotic, feelings of unpreparedness, a loss of control, and the fear of harm to the baby. Heightened anxiety

responses were described as distressing to women and contributed to a predominantly negative experience of the operative process.

(c) Disappointment

For nine of the women, the desire to have a natural birth encompassed the idea 'of the baby coming out through the canal, and the closeness, the bond that you form then in that process' (Mom 1). After having a Caesarean delivery, mothers felt robbed of an intimate birth experience; 'like it was taken away from me' (Mom 2). Feelings of disappointment were primarily associated with unmet expectations of the birthing experience. As Mom 4 explained, 'It didn't go the way I had wanted it to go, the way I had prepared for. It wasn't what I had been dreaming of, and the thoughts, or feelings, weren't what I had imagined them to be. It wasn't what I had wanted.'

For some mothers, a Caesarean delivery represented a failure on their part: 'I failed to be able to give birth naturally ... I sometimes blame myself for not pushing harder' (Mom 5). The disappointment of an unsuccessful natural delivery led to self-doubt and feelings of regret. This resulted in women wondering 'what have I done wrong?' (Mom 1), and questioning their abilities as both women and mothers: 'I thought I had failed myself and womankind as a whole' (Mom 3). Women's disappointment and dissatisfaction in themselves and the birth process was significant in that, even when the outcome was a healthy baby, it tainted their overall perception and recall of the birth experience.

(d) Anticipation

Despite the anxiety, uncertainty and distress experienced during an unplanned Caesarean section, mothers awaited their babies with excitement and anticipation: 'You're really happy that this is finally happening and this thing is finally coming' (Mom 9). Acknowledgement of the imminent arrival of their baby was a powerful reminder of the positive expectations and emotions associated with pregnancy. Mom 1 explained that: 'It's fantastic at the same time

because you also realise that this is it; your baby is being born, this life is coming into the world, and you're aware of this miraculous moment.'

This eager expectancy helped to alleviate some of the pessimistic feelings associated with having had a Caesarean delivery. On hearing their babies' initial cries, or on holding their babies for the first time, mothers' apprehensions and anxieties associated with the Caesarean section dissolved. Feelings of relief and gratefulness referred to a perception that despite the traumatic delivery experience, 'it is all about a happy, healthy baby. That is more important than anything else' (Mom 3). Thus, the powerful and overwhelming joy and relief felt by mothers on meeting their babies contributed to more positive perceptions of the birth outcomes.

(e) Post-partum responses

Post-partum responses to unplanned Caesarean section varied from positive adjustment to motherhood to traumatic emotional reactions. These included acute stress responses, post-partum 'baby blues' or depressive symptoms, and grief.

Despite the trauma associated with unplanned Caesarean section, five of the mothers experienced the emotional adjustment during the post-partum period as relatively uncomplicated. Affectionate recollections of mother-infant bonding, family union, and maternal role acquisition illustrated positive post-Caesarean experiences: 'All thoughts of the process disappear and you're so aware of this little life ... I just stopped focusing on myself, and let myself think about him. God had blessed with me with this baby, and knowing that I was given the ability to love him just made it easier' (Mom 1).

For five of the women, however, the experience of early motherhood was marred by emotional disturbance. This was associated with the trauma of the unplanned Caesarean section. These mothers reported traumatic stress reactions during the post-partum period.

Symptoms included a sense of emotional numbness, such as an absence of relation to the baby, avoidance of things related to the birth, such as the baby, and heightened levels of arousal, such as insomnia and anxiety about the baby's health: 'Afterwards, I was extremely scared to even go to sleep and to leave the child alone. For the first couple of nights I didn't sleep. I was just too scared that something was going to happen' (Mom 8).

Some mothers also reported symptoms of depression. These included psychomotor retardation, a decreased interest in normal activities, irritability and anger, disturbed sleeping patterns, reduced concentration levels, fatigue, low energy levels, feelings of worthlessness or guilt, and persistent sadness: 'I should've been happy but I was just crying for so long and no one knew why ... I just really, really battled' (Mom 10).

Symptoms of grief after the unplanned Caesarean section included sadness, anger, and guilt. As Mom 7 explained, 'Thinking about my first child and that whole period, I can only think about the horrible stuff and everything that went wrong, rather than the time with this new baby in the house, and all that nice stuff ... Walking her, carrying her, moving, sitting, coughing, sneezing, laughing, was all stuff that I couldn't do.'

The occurrence of traumatic post-partum emotional responses coloured women's already negative perceptions of childbirth by prolonging the distress experienced during the unplanned Caesarean section and hindering recovery. In these instances, the post-partum period and the transition to motherhood was complicated by mother's own emotional adjustment difficulties.

DISCUSSION

Becoming a mother is a life-changing event and a status passage, particularly for first-time mothers (Fenwick et al., 2009). Many women enter labour with particular anticipations of the birth and it has been shown that whether or not expectations are met, women still consider

them to be important after delivery (Lavender et al., 1999). It has been suggested that forming a positive appraisal of birth depends on how well events have lived up to expectations; studies have shown that when such expectations are fulfilled, women report higher levels of satisfaction (Baston et al., 2008; Hauck et al., 2007; Tulman and Fawcett, 2003). Conversely, when anticipations differ from reality, perceptions and feelings in relation to unmet expectations may then have the potential for producing adverse emotional consequences (Gibbons and Thompson, 2001).

In this study, an unplanned Caesarean section was described as a distressing, difficult and disappointing experience for women; one that confronted mothers with considerable adjustment difficulties. Darvill et al. (2008) explain that a disruption of the expected natural continuity between pregnancy, delivery and motherhood can be both negative and traumatic. Feelings of disappointment were primarily associated with unmet expectations; that is, the experience had not been what women had hoped and planned for. Despite having a healthy baby, their expectations influenced whether mothers considered their experience to be a fulfilling one or not.

Mothers spoke of feelings of failure after their Caesarean sections. Studies by Hillan (1992), Creedy et al. (2000), and Ryding et al. (2000) confirm that women who experience a Caesarean section may have increased feelings of disappointment, a diminished sense of self, and a lowered self-esteem. Feelings of inadequacy were associated with a sense that their body had failed, leading to the loss of the desired natural birth. In addition, women experienced feeling a failure as a mother. Fenwick et al. (2009) point out that these feelings of guilt are associated with women not having been able to give their babies the birth they had anticipated for them.

This research further suggests that physical factors have a significant influence on women's perceptions of childbirth. For the women in this study, physical obstacles included pain in the

first stage of labour, prolonged labour, pain and fatigue that resulted from having a major operation, medical complications, and a taxing recovery period. As evidenced in other research, the presence of physical pressures and complications can modify the psychological impact of a Caesarean delivery (Karlstrom et al., 2007; Clement, 2001), where physical distress may contribute to perceptions of the delivery experience as traumatic (Beck and Watson, 2008). Feelings of physical invasion and exposure, together with physical reactions to medication and anaesthesia, described as feelings of detachment, can be experienced as unsettling. Such disconcerting disconnection can lead to experiences of de-realization (Clement, 2001; Fenwick et al., 2003; Ryding et al., 1998). Several studies on unplanned Caesarean section (Fawcett et al., 1993; Reichert et al., 1993) suggest that a sense of dissociation due to the effects of anaesthesia can leave mothers with a sense of having 'missing pieces' in their birth experiences.

Preparation played a significant role in mothers' experiences of an unplanned Caesarean section. Culmination of the birth in a Caesarean section was anxiety-provoking for women who felt unprepared and had little knowledge of the processes involved. These results correlate with research findings that show women could perhaps feel unprepared for childbirth, which they may attribute to either a lack of information or their own unrealistic expectations (Nelson, 2003; Lavender et al., 1999; Barclay et al., 1997). With little time to prepare mentally for the operation, not knowing what to expect fostered a sense of panic and feelings of helplessness in women in this study. The experience of an unplanned Caesarean section was therefore described as an 'emotional rollercoaster'; a regularly emerging theme in qualitative research on unplanned Caesarean sections (Fenwick et al., 2009; Darvill et al., 2008). The frantic rush of preoperative and operative events aroused overwhelming feelings of anxiety and uncertainty. The series of rapid psychological adjustments, described as intense emotional turmoil, contributed to perceptions of the birth as traumatic.

In this study, caregiving by medical personnel contributed significantly to women's perceptions of childbirth. Research on women's experiences of Caesarean childbirth consistently suggests that the perceived quality of care received has an important influence on the psychological impact of a caesarean section (Waldenström, 2004; Parratt, 2002; Clement, 2001). Attentive, considerate and sympathetic caregiving was reported to affect mothers' experiences of birth by unplanned Caesarean section positively, by contributing to a sense of support.

Mothers reported a more positive experience if the Caesarean section was perceived as having been necessary for the baby's health and well-being. For these women, an understanding of the medical reasons that necessitated surgical intervention was significant in determining the level of acceptance of the failed natural birth. This was associated with recognition of the Caesarean section as having been a life-saving procedure, rather than a reflection of the mother's own inadequacies. This is consistent with research that indicates that communication by the health-care professionals is an important factor in promoting women's understanding of the indications for an operative birth, and whether women have positive or negative memories of the event (Fenwick et al., 2009; Murphy et al., 2003). In this study, women who felt that they had been informed and involved in decision-making were more positive about having relinquished control to caregivers. For some women, inadequate communication from staff was both frustrating and anxiety-provoking. In these instances, mothers reported feelings of uncertainty and insecurity. Moreover, they were left feeling excluded, dismissed and insignificant.

These descriptions of feelings of detachment, vulnerability, helplessness, and insecurity all allude to the significance of a power variable. When preconceptions and expectations, dignity or esteem were challenged, the sense of loss of control was overwhelmingly distressing and anxiety-provoking for women. For them, this sense of loss of control was described in relation to a loss of physical and/or emotional control. In this study, *loss of*

control therefore appeared to be the central contributor to women's negative childbirth experiences.

Findings are consistent with research which suggests that adjustment to emergency Caesarean delivery is related to the degree to which mother's can establish a sense of control (Al-Nuaim, 2004). Women who recall a sense of being in control of events during labour and delivery are more satisfied and have greater post-natal emotional well-being (Brown, 1994). On the other hand, for many women, a Caesarean section is associated with losing control (Fenwick et al., 2009; Gibbons and Thomson, 2001). Losing control has thus been linked with feeling a loss of normality, and therefore with an undesirable delivery outcome (Olde et al., 2006; Fenwick et al., 2009; Allen, 1998; Wijma et al., 1997).

Mothers described a sense of loss at not having given birth to their babies themselves. Giving birth by means of unplanned Caesarean delivery has been found to be associated with compromised early mother–infant interaction (Rowe-Murray and Fisher, 2001; DiMatteo et al., 1996; Sethi, 1995). Delivery by Caesarean section was perceived as having been impersonal, with mothers describing a sense of disconnection and a loss of intimacy between mother and infant. For some mothers, these feelings dissipated on initial contact with their babies. Other mothers reported a gradual bonding process in their relationships with their babies. In either instance, mothers' emotional reactions to their babies were positive and counterbalanced the trauma of the Caesarean section to some extent. Research (Nystedt et al., 2008; Fenwick et al., 2009) suggests that for some women, becoming a mother after the emotionally challenging unplanned Caesarean section involves feelings of having a deep and significant bond with their babies.

For some mothers in this research, the transition to motherhood was complicated by traumatic responses. Although not directly or conclusively correlated, women associated psychological morbidity in the post-partum period with an adverse birthing experience. This

is consistent with recent research findings which have suggested that a negative evaluation of the birth experience is a risk factor for acute trauma stress reactions (Alder et al., 2006; Ryding et al., 1998; Ayers, 2007), post-partum 'baby blues' or depressive mood disturbances (Noriko et al., 2007; Lobel and Stein DeLuca, 2007; Robertson et al., 2004), grief (Nystedt et al., 2008; Ryding et al., 1998, Olde et al., 2006), or some combination of these.

Support from family, friends and professionals had a significant effect on perceived levels of coping for women in this study. Many studies have identified the contribution of supportive care to a positive evaluation of the birth (Baston et al., 2008; Hauck et al., 2007; Lavender et al., 1999; Waldenström, 2004). The most important source of support and encouragement for women came from their husbands. The familiarity and company of their partners provided a sense of comfort and security throughout the birth experience. These findings are supported by other studies, which describe partners as valuable in providing support, encouragement and reassurance, and in helping a woman to maintain control and acting as her advocate (Gibbons and Thomson, 2001; Lavender et al., 1999).

CONCLUSIONS AND LIMITATIONS

The experience of an emergency Caesarean section has been identified as a potentially traumatic experience, which has added to professional understanding of the adverse emotional consequences of surgical delivery on childbearing women (Creedy et al., 2004). This exploration has important implications for therapeutic intervention, preventive measures and guidance. Professionals involved in prenatal care should consider strategies for preventing post-Caesarean psychological distress through greater prenatal preparation for Caesarean deliveries. Findings also draw attention to the encounter between the women and the hospital staff. Staff should be aware of the importance of positive encounters between themselves and women, as this will affect their levels of satisfaction, comfort and support. These findings can contribute to midwifery and nursing literature by highlighting the difficulties associated with adjusting to an unplanned Caesarean section. Caregivers should

be aware of the range of possible psychological responses to Caesarean section so that they may recognize psychological difficulties and distresses in the Caesarean mothers they care for, and so that they are able to provide the appropriate care and support. Moreover, the qualitative data contribute to the continuously developing body of knowledge about the diversity of mothers' experiences of unplanned Caesarean sections.

Several methodological limitations may underestimate or misrepresent the impact of the present study. The small sample may limit the generalizability of results. The study did not discriminate between planned versus unplanned pregnancies. This distinction could have important implications for the levels of preparedness, anxiety, and adaptation experienced. Furthermore, this research did not control for the use of instruments (e.g. forceps) or other interventions (e.g. labour induction) which may obscure subjective experiences. The women that participated in this study were all white. Within the South African context, there are women from other racial groups who experience unplanned Caesarean sections. These women live in communities that hold different cultural values and it is important that their perspectives be explored to investigate how different cultural backgrounds influence women's experiences of unplanned Caesarean sections. It is also possible that the effect of childbirth may have changed over time. As time passes, positive affect for one's role as a mother may favourably colour a woman's feelings about her birthing experience (Waldenström, 2004).

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TABLE 1. Themes associated with the experience of birth by unplanned Caesarean section

The physical experience

(a) The experience of pain

Painful labour leading up to the Caesarean

Pain as a result of medical complications

Painful recovery post-Caesarean

Painful breasts

(b) The experience of exhaustion

Weakness and tiredness during labour

A difficult and tiring recovery process

(c) The effect of medication

Physical illness as a reaction to medication

Feeling detached / spaced out as a consequence of taking medication for pain

Feeling drowsy and sedated after taking medication

(d) Loss of privacy

Feelings of vulnerability and exposure

The experience of the environment

(a) The experience of clinical surroundings

The lighting and walls experienced as white and sterile

Hospital rooms experienced as unwelcoming and uncomfortable

(b) The experience of activity

Several activities happening simultaneously

Multiple interpersonal interactions

(c) The experience of other women

Comparison and evaluation of self in relation to others

(d) Support

Support from husband

Support from family, friends and professionals

The experience of medical staff

(a) Experiences related to aspects of staff members' personalities

The impact of reassurance and soothing

(b) Experiences related to aspects of staff members' behaviour

Factors relating to staff's composure during the Caesarean section

Factors relating to staff's attentiveness and caregiving post-Caesarean section

(c) The role of communication

The role of decision-making power

The extent to which women felt respected and involved

The level of understanding that mothers achieved through communication

The emotional experience

(a) Frustration

Feelings of being disrespected and ignored by staff

Feelings associated with physical limitations post-partum

(b) Anxiety

A sense of concern for one's baby's health

Feelings related to the speed and associated sense of emergency of the situation

Feelings of confusion and uncertainty related to unpreparedness

(c) Disappointment

Feelings related to unmet expectations

Feelings associated with a sense of loss of intimacy

Disappointment in oneself for not being able to successfully deliver naturally

Feelings of regret

(d) Anticipation

A sense of excitement about seeing their babies

Feelings of relief as mothers' babies were seen, held or heard

(e) Post-partum response

Healthy post-partum adjustment

Acute traumatic responses

'Baby blues' or depressive symptoms

Grief

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No one can whistle a symphony.

It takes a whole orchestra to play it.

~H.E. Luccock

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- ❖ ALL THE TEARS THAT FELL. THEY WERE WORTH IT.

STATEMENT

I, Samantha Lynne Roux, declare that the dissertation (article format) hereby submitted by me for the degree Magister Scientiae in Clinical Psychology at the North-West University is my own independent work, based on my personal study and/or research. I have acknowledged all material and sources used in its preparation, whether they be books, articles, reports, lecture notes, or any other kind of document, electronic or personal communication. I also certify that this assignment/report has not previously been submitted for assessment at any other unit/university/faculty, and that I have not copied in part or whole or otherwise plagiarised the work of other students and/or persons.

S. L. Roux

LETTER OF CONSENT

Permission Statement to Submit Article for Degree Purposes

I, the supervisor, hereby declare that the input and effort of Samantha Roux in writing this article is of sufficient scope to be a reflection of research done by her on this topic. I hereby grant permission that she may submit this article for examination purposes in partial fulfilment for the degree Magister Scientiae in Clinical Psychology.

Prof. E. van Rensburg

INTENDED JOURNAL AND AUTHOR GUIDELINES

Intended journal: **International Journal of Nursing and Midwifery**

The manuscript has been styled according to the above mentioned journal's specifications (www.academicjournals.org).

INTERNATIONAL JOURNAL OF NURSING AND MIDWIFERY

Editors: Dr. Alleene M. Ferguson Pingnot, Dr. Andrew Crowther, Dr. Jacinta Kelly,
Dr. Jafar Alasad and Dr. Fintan Sheerin

Publisher: Academic Journals

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International Journal of Nursing and Midwifery (IJNM) is an open access, multidisciplinary, peer-reviewed journal dedicated to expanding knowledge in all areas of the subject.

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The Journal welcomes the submission of manuscripts that meet the general criteria of significance and scientific excellence. Manuscripts already under review elsewhere or similar to a previously published manuscript will not be considered for publication. Electronic submission of manuscripts is strongly encouraged, provided that the text, tables, and figures are included in a single Microsoft Word file. Manuscripts are to be submitted as an e-mail attachment to the Editorial Office at ijnm@academicjournals.org or ijnm@acadjourn.org. The cover letter should include the corresponding author's full address and telephone/fax numbers. The file, beginning with the first author's surname, should be included as an attachment.

Manuscript Preparation

Paper: Standard-sized (22 x 28 cm), heavy white bond paper.

Preferred typeface: 11-pt Arial.

Spacing: Double-spaced (including all notes and references).

Page numbers: All pages are numbered consecutively, beginning with the title page.

Order of manuscript pages:

- Title page
 - The title should be a brief phrase describing the content of the paper.
- Abstract
 - The abstract should be informative and completely self-explanatory. It should briefly present the topic, state the scope of the experiments, indicate most significant data, and point out major findings and conclusions.
 - The abstract should be 100 to 200 words in length.
 - The abstract should be written in the past tense. Complete sentences, active verbs, and the third person should be used. Standard nomenclature should be used and abbreviations should be avoided. No literature should be cited.
 - The abstract should be followed by a list of 3 to 10 ten words for indexing referencing purposes.
- Text
 - The length of the full paper should be the minimum required to describe and interpret the work clearly.
 - The introduction should provide a clear statement of the problem and the relevant literature on the subject.

- Materials and method should be complete enough to allow experiments to be reproduced. Subheadings should be used.
- Results should be presented with clarity and precision. The results should be written in the past tense when describing findings. Previously published findings should be published in the present tense.
- The discussion should cover speculation and detailed interpretation of data.
- The results and discussion sections can include subheadings and, when appropriate, can be combined.
- Conclusions should be provided in a few sentences at the end of the paper.

Abbreviations:

A list of non-standard abbreviations should be provided. In general, non-standard abbreviations should be used only when the full term is very long and used often. Each abbreviation should be spelled out and introduced in parentheses the first time it is used in the text. Only recommended SI units should be used. Authors should use the solidus presentation (mg/ml). Standard abbreviations (such as ATP and DNA) need not be defined.

Tables:

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Examples:

- Chikere CB, Omoni VT and Chikere BO (2008). Distribution of potential nosocomial pathogens in a hospital environment. *Afr. J. Biotechnol.* 7: 3535-3539.
- Moran GJ, Amii RN, Abrahamian FM, Talan DA (2005). Methicillin resistant *Staphylococcus aureus* in community-acquired skin infections. *Emerg. Infect. Dis.* 11: 928-930.
- Pelczar JR, Harley JP, Klein DA (1993). *Microbiology: Concepts and Applications*. McGraw-Hill Inc., New York, pp. 591-603.

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**An exploratory study of mothers' perceptions and experiences of an unplanned
Caesarean section**

AUTHORS

S. L. Roux* (MSC Clinical Psychology) (Student)

Oakfields 179

Paperworks X43

Benoni

1501

Republic of South Africa

Tel: +27 82 324 2964

Fax: +27 11 963 0817

E-mail: samantha.roux1@gmail.com

Prof. E. van Rensburg (PhD Child Psychology)

School of Psycho-Social Behavioural Sciences

North-West University, Potchefstroom Campus

Private Bag X6001

Potchefstroom

2520

Republic of South Africa

Tel: +27 18 299 1731

Fax: +27 18 299 1730

E-mail: esme.vanrensborg@nwu.ac.za

*To whom correspondence should be addressed

MANUSCRIPT FOR EXAMINATION PURPOSES

SUMMARY

Pregnancy and childbirth are important life experiences in a woman's psychosocial and psychological development. For many women, vaginal birth is still considered an integral part of being a woman and becoming a mother. Furthermore, it is thought to promote maternal well-being through helping women to match their expectations to experiences. For these women, a failed natural birth is a psychological, psychosocial, and existential challenge that can result in significant and far-reaching consequences for their psychological well-being.

According to literature, women who deliver by Caesarean section differ significantly from those who deliver vaginally regarding their childbirth experiences. Those who deliver by Caesarean section are often less satisfied, both with the birth experience and with themselves. They experience a feeling of resentment towards the physician, profound disappointment in the treatment expectation, and loss of the joyful moment of natural birth. Furthermore, Caesarean delivery carries considerable physical disadvantages in terms of the pain and trauma of an abdominal operation. Mothers may be confronted with considerable adjustment difficulties in adapting to not being able to fulfil their dreams of delivering their babies naturally. In some instances, the negative experience of an unplanned Caesarean section may lead to post-partum depression or post-traumatic stress.

This research aimed to explore and understand the subjective perceptions and experiences of a group of South African women who had delivered their babies by unplanned Caesarean section. Through purposeful sampling, ten mothers who had wanted to deliver their babies naturally, but had not been able to for whatever reason, were selected as the study sample. Various aspects of their birth experiences were explored in in-depth phenomenological interviews that allowed the researcher to probe certain aspects offered by participants in

order to understand and explore their contributions in as much depth as possible. A semi-structured, open-ended approach allowed for the exploration of relevant opinions, perceptions, feelings, and comments in relation to the women's unplanned caesarean experiences. The transcribed data was synthesized within a framework of phenomenological theory, where women's experiences were analysed and explored in an attempt to understand how participants made sense of their experiences.

Results highlighted women's experiences of the medical personnel, as well as of the physical, environmental, and emotional aspects of an unplanned Caesarean section. For most of the women, the experience was distressing and traumatic. A sense of loss of control was the most significant contributor to their negative childbirth experiences. Feelings of failure and disappointment were primarily related to unmet expectations and a lack of preparedness. Positive mediators of the mostly negative experience included attentive caregiving, feelings of inclusion in decision-making, and support from loved ones.

These findings contribute to psychology, midwifery and nursing literature by highlighting the emotional and physical difficulties associated with adjusting to an unplanned Caesarean section. However, the restricted sample may limit the generalizability of results. Further investigation of the experiences of a larger, more biographically and culturally diverse population could be instrumental in the development of knowledge and understanding in this field of study.

Keywords: subjective perceptions; childbirth experience; unplanned Caesarean section; adjustment; phenomenological research

OPSOMMING

Swangerskap en kindergeboorte is belangrike lewenservarings in 'n vrou se psigososiale en sielkundige ontwikkeling. Vir baie vroue is vaginale geboorte steeds onlosmaaklik deel van hulle vrou-en-moederwording. Verder word gemeen dat dit moederlike welstand bevorder deur vroue te help om hul verwagtings en ervarings met mekaar te laat ooreenstem. Vir hierdie vroue, is 'n mislukte natuurlike geboorte 'n sielkundige, psigososiale en bestaansuitdaging, wat kan uitloop op aansienlike en verreikende gevolge vir hulle sielkundige welstand.

Volgens literatuur verskil vroue wat deur middel van 'n keisersnit geboorte skenk ten opsigte van hul kindergeboorte-ervarings aansienlik van dié wat vaginaal geboorte skenk. Diegene wat deur middel van 'n keisersnit geboorte skenk, is dikwels minder tevrede, beide met die geboorte-ervaring en met hulself. Hulle koester 'n gevoel van wrewel jeens die geneesheer, is intens teleurgesteld in die verwagte behandeling en voel die vreugdevolle oomblik van natuurlike geboorte het verlore gegaan. Voorts hou 'n keisersnitgeboorte aansienlike fisiese nadele in ten opsigte van die pyn en trauma van 'n abdominale operasie. Moeders kan met aansienlike aanpassingsprobleme te kampe hê om hulself te probeer versoen met die feit dat hulle nie hul drome kon verwesenlik om hul babas natuurlik in die wêreld te bring nie. In sommige gevalle, kan die negatiewe ervaring van 'n onbeplande keisersnit tot nageboortedepressie of posttraumatiese stres lei.

Die doelwit van hierdie navorsing was om die subjektiewe persepsies en ervarings van 'n groep Suid-Afrikaanse vroue wat hul babas deur 'n onbeplande keisersnit in die lewe gebring het, te ondersoek en te begryp. Deur doelgerigte steekproefneming is tien moeders wat natuurlik geboorte wou skenk maar dit om verskillende redes nie kon doen nie, as die deelnemers gekies. Verskeie aspekte van hul geboorte-ervarings is in indringende

fenomenologiese onderhoude ondersoek wat die navorser in staat gestel het om sekere aspekte van die deelnemers se bydraes in soveel diepte as moontlik te begryp en te ondersoek. 'n Semi-gestruktureerde, oop-einde-benadering het dit moontlik gemaak om relevante menings, persepsies, gevoelens en kommentaar ten opsigte van die vroue se onbeplande keisersnit-ervarings te verken. Die getranskribeerde data is binne die raamwerk van fenomenologie teorie gesintetiseer. Die vroue se ervarings is ontleed en verken in 'n poging om te begryp hoe deelnemers sin van hul ervarings gemaak het.

Resultate het vroue se ervarings van die mediese personeel en die fisiese, omgewings, en emosionele aspekte van 'n onbeplande keisersnit verken. Vir die meeste vroue was die ervaring ontstellend en traumaties. 'n Gevoel van verlies aan beheer was die belangrikste bydraende faktor tot die vroue se negatiewe kindergeboorte-ervarings. Gevoelens van mislukking en teleurstelling was primêr verbonde aan onvervulde verwagtings en 'n gebrek aan voorbereidheid. Die oorwegend negatiewe ervaring is versag deur goeie versorging, gevoelens van insluiting in die besluitnemingsproses en die ondersteuning van geliefdes.

Hierdie bevindings dra by tot sielkundige, vroedvrou- en verpleegkundige literatuur deur die emotionele en fisiese probleme uit te lig wat gepaard gaan met aanpassing by 'n onbeplande keisersnit. Die klein steekproefgroep kan egter die veralgemening van resultate inperk. Verdere ondersoek van die ervarings van 'n groter populasie met meer biografiese en kulturele diversiteit kan beduidend bydra tot die ontwikkeling van kennis en begrip in hierdie studieveld.

Keywords: subjektiewe persepsies; kinderboorte ervarings; onbeplande keisersnit; aanpassing; fenomenologiese navorsing