WOMEN'S EMOTIONAL RESPONSES TO THEIR UNPLANNED CAESAREAN DELIVERIES: IN WOMEN'S WORDS

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ABSTRACT

In Canada, one in five women can now expect to deliver their baby by caesarean section. For some women, this method of delivery creates little concern, but for others, birth by caesarean causes emotional trauma that can last for years. Childbirth was historically regarded as a natural event and was undertaken with little assistance from health professionals. However, with urbanization and medical advancements, childbirth soon became a medically managed process. During the Women's Health Movement of the 1970's, women reacted to the medicalization of birth by calling attention to the emotional reactions of women following childbirth, with particular attention paid to deliveries by caesarean section.

This paper discusses interviews with five women who sought the assistance of a community support and awareness group following a negative emotional response to an unplanned caesarean section. Qualitative research methods were used in order to capture the participants' unique experiences during and after childbirth. The women described feelings of fear, failure, disappointment, and loss of control. They perceived that the medical staff was generally uncaring and dismissive of their concerns. Each participant felt that the support group was instrumental in helping them to recover from the trauma of their birth experience, but also reported that they would have appreciated the opportunity to speak with a social worker following the birth.

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INTRODUCTION

Mothers anticipating the birth of their children usually envision a birth attended by encouraging nurses, a supportive partner, and a doctor seated at the end of the delivery table to catch the baby. For many mothers this is their reality. For many others it is not. In Canada, the average rate of caesarean delivery is 22.5% (CIHI, 2004). This means that more than one in five children are born by caesarean section. For the mothers of these children, the birthing experience can result in disappointment, feelings of failure and guilt, as well as relief at having a healthy baby. Women can feel isolated, alone with their emotions and believing that they are the only ones experiencing these conflicting feelings.

Historically the culture surrounding childbirth has been associated with a woman's rite of passage into adulthood. She gave birth at home and was attended by other females and often by a midwife. The 19th century saw the shift from midwife-attended births to doctor-attended births. In a short time, the majority of births occurred in hospital as the medical establishment shifted the perception of birth from a natural process to a pathological event that required the monitoring and intervention of physicians. The medical community began to view not only the mother but also the unborn child as the primary patient. As a result, more intrusive measures were taken to ensure the safe birth of the child. These measures led to a rise in the use of instruments to aid vaginal delivery as well as an increased dependence on caesarean sections to produce

"good outcomes". Due to the establishment of the medical monopoly on birth, physicians were regarded as the experts on this once natural event. As a result, parents felt they had no choice but to heed the advice of the physician when a caesarean was suggested, otherwise, the parents risked being regarded as incapable of viewing the needs of their child as paramount. Undoubtedly, most mothers felt that they had acted in the best interest of their child, but some mothers also had difficulty making sense of their emotional response to the caesarean section.

The Women's Health Movement of the 1970's helped women to voice the need to be included in decisions regarding the birth of their child, a desire for less medical intervention and the need for more emphasis on nurturing. Women began to challenge the medical view of childbirth and to question the necessity of the high rates of caesarean sections. Studies were conducted that focused on the emotional responses of women to unplanned caesarean sections, and researchers recommended changes in childbirth practices to the medical community (Affonso, 1980; Marut, 1978; Sandelowski, 1984). Currently in Ontario, the provincial government has recognized that the rates of caesarean deliveries is higher than the rate recommended in the guidelines from the World Health Organization. In response, the provincial government has taken steps to examine hospitals with caesarean section rates below the provincial average in an effort to determine best policy and practice. Despite these actions, the rate of caesarean deliveries continues to increase.

Currently, the health care system provides nominal support to women who gave birth by caesarean section and fails to recognize the emotional costs associated with a

caesarean delivery. Hospitals do not evaluate the emotional well being of new mothers who return home facing the dual challenges of becoming a parent and coping with conflicting emotions related to the delivery. The prevailing social attitude expects women who have undergone caesarean deliveries to be thankful that they have a healthy child and access to the medical technology that made the delivery possible.

This study will give voice to five mothers who have undergone unplanned caesarean deliveries and who view their experience as a predominantly negative event. This paper will identify the dominant emotions of the women, the women's perception of the medical professionals involved with the birth, and how the women related to the care providers and support people that assisted the birthing process. There will be a discussion of the gaps between birth expectations and outcomes, as well as the coping methods employed by these women. Implications for social work practice and directions for further study are presented.

A REVIEW OF THE LITERATURE: FROM NATURAL TO MEDICAL – THE EVOLUTION OF CHILDBIRTH[1]

In Ontario today approximately one in five women deliver their baby by caesarean section. For half of these women it will be their first caesarean delivery, usually unplanned and promoted as a medical emergency. Women are no longer shocked to hear that a friend or relative has had a caesarean delivery and many mothers having undergone this procedure consider it quite normal. However, this is not the case for all women. Mothers delivering by unplanned or emergency caesarean may feel conflicting emotions related to the relief of producing a healthy child but having a birth experience they had neither planned for nor expected. The literature concerning the response of women to an unplanned caesarean section is consistent in that some women experience disappointment and failure because of the lack of involvement and control in the birth process.

Childbirth: A Historical Perspective

Childbirth practice has undergone a variety of changes in recent history. In order to better understand childbirth today, an examination of historical accounts is needed with particular attention to the changing roles of women with respect to birth in mainstream North American culture. Prior to the 19th century, birth was considered a female event and characterized as 'social childbirth' (Wertz & Wertz, 1977). Women

[1] Some of the material presented in this section of the thesis was previously submitted in a paper for SW733.

could expect support from other women during labour and delivery, as well as during the postpartum period when the community would offer gifts of food or housework to the family. The birth took place in the home and women in labour were usually accompanied by female relatives and/or a midwife.

Midwives were women from the community who had apprenticed with other midwives and had attended a large number of births. Knowledge was passed from one midwife to another and training was 'hands on', with no formal schooling. Midwives believed that they had little control over the birth and were only in attendance to offer support and guidance to the labouring woman. Birth during this time was considered perilous for both mother and child, occasionally resulting in the death of one or the other or both (Dye, 1996). Childbirth was regarded as out of the control of humans and in the 'hands of God' (Dye, 1996). Even as the first physicians began attending the homes of women in labour, they had little influence over the process and were as powerless as their midwife counterparts to make the birth safer and easier (Dye, 1996).

Urbanization and the development of medical schools resulted in an increase in the number of physician-attended deliveries. The sharing of information between physicians became possible through the schools and medical knowledge increased considerably. Information pertaining to childbirth came from Europe, and soon North American physicians were well versed in the anatomy and physiology of gestation, as well as birth technology that included the use of instruments to assist with difficult labours (Wertz & Wertz, 1977). Midwives, however, had no access to this new information and technology, and soon their expertise were being called into question by

the physicians who claimed to have the knowledge and skill required to provide women with a safer and less painful birth (Wertz & Wertz, 1977). The introduction of forceps, the use of sterilization and the safe use of anesthetics and chloroform allowed physicians to solidify claims of childbirth expertise, and women began to attend the hospitals where physicians practiced in order to participate in these new birth procedures (Dye, 1986). Hospitals allowed male physicians to exercise greater control over patients, increased the number and range of births physicians attended, and promoted the idea that childbirth was a dangerous venture requiring medical intervention (Hockey, 1993).

As time went on and more women went to hospitals to deliver their baby, birth was removed from the public sphere and became the domain of the physician. Community births were increasingly rare, and women became less knowledgeable about the birthing process, to the point that they felt no option but to trust in the care of a physician. Physicians monopolized the knowledge of birth and birth itself became mystified (Dye 1986). What was once defined as a natural process had been redefined as a pathological event that routinely required the intervention of trained professionals.

Caesarean Sections

Caesarean sections were first used to retrieve a child from the womb of an already dead mother, usually for the purposes of baptism (Flamm, 1990). In the 18th century there is an account of a Swiss hog gelder operating on his wife following a prolonged and difficult labour, after the attending physician refused to do so. It is reported that this

woman survived the surgery and went on to bear more children who were delivered vaginally (Flamm, 1990).

The use of caesarean sections for delivery became more common in the late 1800's with increased medical management and intervention in childbirth and the introduction of the routine use of anesthesia (Sewell, 1993). As caesarean sections became safer, predominately due to the use of proper sterilization to reduce septic infections, some physicians argued against delaying surgery. They reasoned that an early surgery could improve the outcome as they believed that if a woman was not in a state of collapse when taken into surgery, her recovery would be more certain (Sewell, 1993). Now deemed 'safe', the practice became more frequent and coincided with a reduction in the maternal and perinatal infant mortality rates (Gabert & Bey, 1988; Sewell, 1993). Further medical advancements that made it possible to have regional rather than general anesthesia, and increased government regulations and funding for maternal and child care (making childbirth a concern of the state) contributed to the continued accelerating rates of caesarean sections.

Childbearing Women and Patriarchy

The influence of women was effectively displaced from the process of childbirth through the ostracization of midwives and the mystification of birth. The increasingly popular medical practices and the ever more dominant medical authority, wielded for the most part by men, usurped the power and position of women. It was now the physicians

who held the power to define birth as a crisis situation requiring the use of medical intervention.

The medical model of childbirth was highly paternalistic. Due to their authority and elevation within the social hierarchy, the assertions of physicians became the standard and women with different opinions of birth were silenced through the imbalance in power created by gender and social position. Women, not having the same knowledge as the medical professionals, were viewed as ignorant and therefore better off in the care of a physician, who would decide how best to proceed with the "management of the birth". This view continues to propagate itself, and justifies the need for both medical professionals and the social institution of the hospital as key players in modern birthing (Rothman, 1982).

Historically, physicians promoted birth as a pathological event based on the emerging technology and science of obstetrics. Obstetricians gained the power to formalize the definition of a 'normal' birth, and were effective in challenging the viewpoints of other caregivers, primarily the midwives whom they were displacing. The arguments of the medical community were supported by their newly acquired scientific knowledge and the development of new and powerful technologies. As obstetricians succeeded in constructing the pathological potential of childbirth, they were able to gain control over all births by treating it with an "as if" or "in case" syndrome that could only view childbirth as 'normal' in retrospect (Schriefer, 2001). Society's definition of childbirth as an illness gave almost total control of the birth process to the medical system. Locating birthing in the hospital, rationalized by the pathological definition of

the event, served to deny childbearing women a voice in their own care. They became patients who should submit to medical authority (Summey, 1986). This resulted in the surrender of women's control over the birthing process and reduction of both the individual woman's power and the traditional sphere of influence of women.

The Women's Health Movement: The Response to the Medicalization of Birth

Second-wave feminism, which occurred during the 1960's and 1970's saw women challenge the previously accepted male dominated control over birth and reproduction. The core issue of the Women's Health Movement was women's control over their own bodies. The particular focus on reproduction was concerned with identifying and reorganizing the oppressive conditions under which women lived in relation to men (Hanmer, 1993). Women began to question established procedures surrounding birth and it became clear that science and technology were being used to disempower women by routinely extending interventions that were initially justified only in exceptional circumstances (Sawicki, 1999). Specific techniques identified included fetal monitoring, hormonal drips, ultrasound, inductions, episiotomies and caesareans (Hanmer, 1993). Encouraged by their dissatisfaction and their traditionally subordinate place in society, women began to work together to promote change. Many women-centered organizations were established to provide care for women by women, emphasizing egalitarian relationships and the value of women's experiences (Lundy, 1994). In response to the accelerating rates of caesarean deliveries, large scale

organizations such as the International Caesarean Awareness Network were formed to promote self-education and advocacy for changes in health care (Summey, 1986).

The natural childbirth movement was born from this larger health movement. Women were encouraged to trust their body's relationship with nature and to once again view birth as a natural event that had occurred for millennia without medical management. Although midwives were not legalized, women increasingly wanted homebirths because they felt that medical intervention in birth was not necessary and was a further area of the male dominated medical system's control over women's bodies and experiences (Sawicki, 1999). Lamaze, a birthing framework that initially supported natural childbirth was introduced along with the LeLeche League which encouraged women to opt for breastfeeding instead of the medically promoted bottle feeding (Sawicki, 1999). Activists believed that women should recover control over their own health and that childbirth was the natural place to start since birth had traditionally been regarded as a woman's domain.

As with other movements, this endeavour was not without its problems. The notion of the body's intimate connection to nature was touted as a sign of femininity, and any medical intervention was seen as interrupting that connection, at a cost to the feminine (Michie, 1996). A woman who subscribed to the natural childbirth movement and whose birth resulted in the apparent need for medical services, caesarean delivery being the ultimate intervention, may feel like a failure as a woman because she was unable to perform to her expectations. They could lose trust and confidence in their body and its abilities, and lose faith in themselves for not exercising better control over their

body (Michie, 1996). The idea of a woman managing her own health can also victimize a woman since it places the responsibility on her to know what is best in a given situation. Again, if a situation arises where medical intervention is necessary, the woman may feel disappointment that she has had to seek outside involvement for what is supposed to be a "natural process". This also deflects attention from the state's responsibility for health care (Hockey, 1993).

The prepared childbirth movement was also a result of the Women's Health Movement. This movement tried to humanize the medical management of birth, not do away with the medical approach, but rather to make birth more pleasant for women and responsive to their needs (Rothman, 1982). Women embraced the use of Lamaze and Bradley methods for managing the pain of childbirth as taught by prepared childbirth educators. However, the instruction of these methods was soon given through hospitals and the thrust of the prepared childbirth movement became a preparation of women for the experience of a medically managed birth (Rothman, 1986). Educators were told to inform patients to expect vaginal exams that could be performed by an assortment of practitioners: the patient's physician, a resident physician, an intern or a nurse. They were further told that it was not for the patient to decide who should or should not examine her during labour (Rothman, 1986).

Barbara Katz Rothman in her book "In Labour" is critical of the prepared childbirth movement (1982). Central to the movement was the promotion of breathing techniques for pain management, but Katz Rothman states that in emphasizing pain and its control, the childbirth education groups reinforced the medical model of childbirth as a

crisis situation (Rothman, 1982). Both the educators and the physicians in this movement are in accord that childbirth pain requires professional assistance in its control (Rothman, 1982), further emphasizing the need for medical intervention in the birth process. Although the prepared childbirth movement sought to educate women about childbirth, it was co-opted by the medical system and ultimately used as a tool to further control birthing women.

Renewed Medical Control

Although the movements toward natural childbirth and prepared childbirth were not without difficulties, they brought the subject of birth to the fore. Women were reintroduced to the issues surrounding their part in the process of birth. Considerable research originated from the Women's Health Movement with regard to women's experiences during childbirth and their subsequent responses to those experiences. Programs were initiated in an attempt to reduce the increasing rates of caesarean sections, and a growing number of organizations were formed with the aim of providing women with education and information about childbirth. The increased presence of research, public education, and woman-centered organizations suggested that women had made considerable gains in the area of birth. It seemed that the voices of women voices were being heard and that their demands for more involvement in the birth process were being heeded by the medical community.

However, the medical community, supported by the social values of patriarchy and technology, fought back. Physicians persisted in characterizing women as needy,

dependant, hysterical, and emotionally unstable (Lundy, 1994). Women were continually rebuffed and patronized when they requested specific services or were vocal about their needs and experiences (Lundy, 1994). Physicians equated women's bodies with machines, and physicians themselves were viewed as the technicians (Lawrence, 2000). Traditional medical models persisted, such as the technology-based ideology in which women were viewed as objects upon which certain procedures must be performed in order to ensure optimal results. In this context, pregnancy and childbirth were at best complications, stresses on the system. At worst, they were pathological, disease-like states. In either case, pregnancy and childbirth were believed to require treatment and medical management (Rothman, 1982). Using this framework, a society that values technology would wonder why, if the means exist to make birth "safe and easy", would it not be used? Advances in technology, such as in-vitro fertilization and in-utero fetal surgery, brought reproduction and childbirth closer to the medical control it was previously under (Sawicki, 1999).

This control was further solidified when the medical community conceptualized the fetus as an independent being who required medical interventions irrespective of the needs of the mother (Rothman, 1989). Women were encouraged to practice "responsible motherhood" and the protection of the fetus became the primary focus of medical professionals and labouring women. To this end, the educators of mainstream childbirth continued to train women to expect and accept medical interventions such as fetal monitors, intravenous drugs, labour induction, forceps, pain medication, and even caesarean section to promote the "best" interests of the fetus (Sawicki, 1999). The

process and management of birth were brought back to the realm of medicine, and less emphasis was placed on women's needs or experiences, implying the loss of gains achieved by the Women's Health Movement.

The Discourse Surrounding Caesarean Sections

The established discourse surrounding birth, and caesarean sections in particular, serves to further marginalize women from their experience of childbirth. In 1920, Joseph DeLee espoused the view that birth was innately a pathogenic situation and that any "abnormality" of childbirth required an interventionist philosophy by obstetricians (Summey, 1986). In 1979, at the height of the Women's Health Movement, Martin Stone reiterated the view of Joseph DeLee to the American College of Obstetricians and Gynecologists. Stone stated: "You know that the trip through the birth canal is the most dangerous trip we ever take with the greatest chance of our dying of any one day in our lives" (Stone, 1979 as cited in Summey, 1986). These images of 'abnormality' and 'danger' serve to project the image of the obstetrician as the rescuer of both women and their babies and to assert the importance of their profession, not just for high-risk births involving identified complications, but for all births.

Pamela Summey (1986) in her chapter "Caesarean Birth" argues that a caesarean delivery is the ultimate medical control over childbirth. Summey suggests that to perform a caesarean section reinforces the ideology of birth as a dangerous event and the importance of the medical professionals who can intervene and deflect that danger (Summey, 1986). This method of delivery also requires little or no participation of the

birthing woman or her family, with the decision to perform a caesarean almost always made by the physicians, and the conditions under which it is performed controlled by the obstetrician and hospital policies (Summey, 1986).

The terminology used by medical staff can be disrespectful of the mother. Obstetricians are seen as the 'deliverers' of the babies (Rothman, 1982). The physician is the active participant while the mother is considered passive, having contributed only indirectly to the birth of her child. There is praise and appreciation to the obstetrician for producing a healthy child and "the social status inherent in the ability to make a baby is shifted from the birthing woman to the medical profession" (Rothman, 1982, p. 178).

'Failure to progress', a firmly negative phrase, is used when a labour is not moving as quickly as medical staff would like. Hearing this can give a woman an immediate sense of failure and fear, both of which are counterproductive to the birthing process. If the correct terminology of dystocia was used, referring to a difficult labour, and explained sensitively and without reference to failure, women may be better able to understand and cope. The phrases 'from above' and 'from below' refer to births via caesarean section and vaginal delivery, respectively, and "In the West, 'up' is good and 'down' is bad: the person who is 'on top' has the status and the power..." (Davis-Floyd, 2001, p. 8).

Further adding to the discourse surrounding caesarean sections are proponents of the natural childbirth movement and the literature that has arisen from that movement. A commonly used text criticizing the high frequency of the use of caesarean sections is "Silent Knife", by Cohen and Estner (1983). This book aims to provide women with

information surrounding the use of caesarean sections and argues that rates of caesarean deliveries are too high as a result of unnecessary medical interventions. It is unfortunate that a book that seeks to educate women can also make women having undergone a caesarean section feel inadequate. Cohen and Estner (1983) refer to a caesarean birth as 'the ultimate unnatural birth' and 'a surgical insult'. They further claim that it is sometimes the mother's lack of confidence in the natural process of birth that leads to a caesarean section (Cohen, 1983), placing the blame on the woman for the unsought outcome.

Others interpret anti-caesarean literature as viewing caesarean birth as an oxymoron. Michie and Cahn (1996) translate this term,

> Stripped of its status as a birth, the caesarean loses its connection to the female body, which acts rhetorically as a guarantor of the natural. The formulation 'caesarean birth' then, repeats the presumed violence of the caesarean, stripping the experience of its connection to the female body (p. 47).

Vaginal birth among this literature is espoused as more mature, more feminine and more intimately tied to the proper relation of reproduction (Michie, 1996). Gayle Peterson (1984) explains in her book, "Birthing Normally" that the process of birth exists within the greater life process of each individual woman and that recognizing beliefs and attitudes affecting labour can render greater opportunity for an uncomplicated labour and birth. Peterson (1984) further claims that women have reacted to oppression by becoming too much like men and that they must not deny their special powers in relation to labour and birth, implying that it is the expression of this power that enables women to have a satisfying birth experience. There is no mention in Peterson's book of the women

who do not have the realization of this natural ability. Even the title of her book serves to make readers who have had a caesarean section feel that they are abnormal and, therefore, in some way deviant and defective.

While the literature arising out of the natural childbirth movement was intended to educate and inform women as to how birth can be viewed as a natural life event, the language used in many of the texts left women feeling that they could not measure up to this movement's expectations, resulting in women feeling further marginalized and isolated.

Caesarean Sections: Canadian Policies

The Society of Obstetricians and Gynecologists of Canada (SOGC) is the organization that governs obstetrical care, and heath care facilities are encouraged to follow SOGC practice guidelines. The provisions include clinical practice guidelines surrounding attendance at labour and delivery, fetal health surveillance during labour, and dystocia.

The guidelines for health professionals attending a woman in labour state that physicians should communicate their availability to patients and discuss whether coverage by another physician will be necessary (SOGC, 1995). The SOGC (2002) recommends that electronic fetal monitoring be in place for women whose pregnancies are deemed to be high-risk, or when labour is induced or augmented by the use of oxytocin for the purposes of fetal health surveillance. Further guidelines suggest there be continuous professional support to the labouring woman, encouragement for the woman

to assume a position which is most comfortable to them, and in the diagnosis of dystocia, adequate time to observe a response to treatment (SOGC, 1995).

In Ontario, dystocia accounts for approximately one half of all primary caesarean sections (SOCG, 1995). The textbook definition of dystocia is "a difficult labour due to mechanical factors produced by the fetus or the maternal pelvis or due to inadequate uterine or other muscular activity" (Mitford, 1992, p. 142). However, the definition of dystocia has expanded over the years and many physicians now use the term dystocia synonymously with 'failure to progress', which can be used in relation to almost any prolonged or difficult labour, providing a blanket justification for the early use of caesarean section. The SOGC (1995) also cautions against the use of epidural analgesia, as there is evidence that its use correlates with an increase in the length of the active stage of labour and a greater risk of caesarean section.

To govern the individual practices of obstetricians, the SOGC (1995) recommends that peer reviews and chart audits be completed to monitor cases of dystocia and failure to progress, and that ongoing evaluations of medical professionals be conducted by their departments in an effort to decrease inter-physician variation and reduce the caesarean section rate.

Contributors to the Use of Caesarean Sections

There are a variety of reasons justifying the use of caesarean sections. Currently, the high rates can be partially attributed to considering the fetus, as opposed to the mother, as the patient (Treichler, 1990). Since unborn children can be examined using

ultrasounds and often treated in utero, there is an increase in parent expectations for a healthy child and a safe delivery. Medical professionals operate under fear of liability and ever increasing pressure to produce a positive outcome (i.e. a healthy baby and mother), which often motivates the early use of caesarean sections (Mitford, 1992).

There is also evidence to suggest that some obstetrical practices contribute to the high rates of caesarean deliveries. For example, the routine use of electronic fetal monitors has been shown to result in an increased number of caesarean deliveries, partially due to the fact that the woman must remain still and lie down on their backs while the monitor is on (Rothman, 1989). This position prevents gravity from helping the baby move down the birth canal. The lithotomy position, with the mother on her back and her legs up in stirrups, further complicates matters yet many hospitals continue to use this position for women during delivery. This position was promoted because the physician had easy access to watch the baby's progress, to help with delivery if needed, and to intervene when he or she felt it necessary (Banack, 2002). It is now known that this position can stall labour, a consequence of which is a diagnosis of dystocia or 'failure to progress', which often results in a caesarean section (Banack, 2002). Similar issues may occur with the use of epidurals as an epidural will often slow a woman's labour (Buckley, 1998). Women having their first baby are particularly affected; choosing an epidural can reduce the chance of a vaginal delivery to less than 50% (Buckley, 1998). Epidurals that have been in place for a lengthy period of time may also cause the baby's heart rate to accelerate making it appear as though the baby is in distress, warranting an emergency caesarean section to avoid risk to the child (Buckley, 1998).

Caesarean rates are also influenced by non-medical factors. U.S. data show that rates are higher for women with private medical insurance, for women who are private rather than public clinic patients, are older, are married, have higher levels of education and are in a higher socio-economic bracket (Lawrence, 2000). This data suggests that caesarean sections may be influenced by profit. There is some evidence that the rate of caesarean deliveries increase around 5:30 pm, before dinner hour, and that there are increased numbers of caesarean deliveries prior to major holidays (Mitford, 1992). It appears as though caesarean sections are sometimes performed for reasons other than maternal or fetal well-being, such as patient or provider convenience or provider legal concerns.

There is also some indication that rates of caesarean deliveries are higher in a tertiary care centre than in a community hospital (Janssen, 2001; Deutchman, 2001). Factors that may account for this are: increased use of ambulation in community hospitals as well as fewer professional caregivers within a community hospital for a woman in labour. Researchers in British Columbia found that practitioners within smaller community hospitals may have practiced with a greater degree of cohesion as influenced by the philosophy of leaders who advocate for a more conservative approach to caesarean delivery (Janssen, 2001). In the tertiary centres studied there was the presence of obstetrical and family practice residency programs that may have encouraged the use of interventions, including epidural analgesic and caesarean sections (Janssen, 2001). It is also the case that tertiary care centres attract patients with complications who may require

obstetrical interventions. It may be that in this environment, there is an inclination to intervene, even with patients without complications (Deutchman, 2001).

Particular physician practices may also account for the variation in rates of caesarean section deliveries within some care settings. Studies that looked at individual practitioners within the same hospital found that there was a wide range of caesarean delivery rates (Goyert, 1989; Guillemette, 1992). Practice style, particularly the management of the second stage of labour (Guillemette, 1992), how long a physician had been practicing, and physician education contributed to the difference in caesarean section rates amongst physicians (Goyert, 1989). There was no difference found in neonatal mortality or trauma as a result of practitioner style (Goyert, 1989; Guillemette, 1992).

At the same time that caesarean section rates are rising, so too are women's expectations of their birth experience. The constant advancements in medical technology are accompanied by the growing expectation of a healthy child and a labour free of complications. In our increasingly litigious society, women whose birth outcomes fall short of these expectations may feel justified in suing their care providers. Obstetricians concerned about their legal standing may err on the side of caution, since a caesarean section is clear evidence that extraordinary efforts were taken, rather than allowing women to have prolonged labours that carry the increased chance of distress for both mother and baby. The committee of the National Consensus Conference of Aspects of Caesarean Birth (NCCACB) noted that there are complex and difficult medico-legal issues related to caesarean sections. "Many physicians feel that some clinical decisions

are unduly influenced by potential litigation pressures and by consumer expectations, which are sometimes unrealistic. The combination of these influences has contributed to the rising rates of caesarean sections" (NCCACB, 1986, p. 1352).

The Picture in Ontario

In 2000/01 the annual provincial rate of caesarean section deliveries in Ontario was 21.7% (OWHC, 2002). In 1998 the caesarean section rates ranged between 14.8% and 24.2% in the various regional district health areas (Statistics Canada, 2000). The rate of primary caesareans accounted for more than half the provincial average at 13.8% (Statistics Canada, 2000). According to a report by the Ontario Women's Health Council (2000), the rates of caesarean deliveries had increased 300% between 1971 and 1986. The years between 1994 and 1997 saw a rise in the caesarean section rate from 17.8% to 19.1% (Health Canada, 2000). This jump was attributed to an increase in the primary caesarean section rate which was more pronounced for women over the age of 25, indicating that a caesarean section is more likely as the mother's age increases (Statistics Canada, 2000). Although the rate of subsequent caesarean deliveries increased slightly between 1994 and 1997, this may be due to the reporting practices focussing on that type of delivery as opposed to a real increase in that population. Following 1997, rates of repeat caesareans declined somewhat, possibly due to increased efforts to promote vaginal births after caesareans (VBAC) (Health Canada, 2000).

In June 2000, the Ontario Women's Health Council (OWHC) released a report titled "Attaining and Maintaining Best Practices in the Use of Caesarean Sections"

(Biringer et al, 2000). The report was commissioned by the Ministry of Health and Long Term Care and examined the practices of four Ontario hospitals that provide the four different levels of care and had achieved a low caesarean section rate. The primary goal of this report was to look at the practice and policies of these hospitals and ascertain how they were able to sustain a rate lower than the provincial average. It was determined that attitude, organization, and knowledge and information were the three key areas that helped these hospitals maintain their lower rates of caesarean deliveries (Biringer et al, 2000). The prevailing attitudes of the hospital staff were: pride in a low caesarean section rate, a view of birth as a normal physiological process, and a commitment to one-to-one supportive nursing care during active labour (Biringer et al, 2000). Strong team leadership, effective multidisciplinary teams, a strong commitment to evidence based practice and timely access to skilled professionals were factors that contributed to the organization of programs. Programs to ensure continuous improvement to quality of care, and an accessible and interactive database reflected the importance of knowledge and information (Biringer et al, 2000).

The council assessing best practices acknowledged that caesareans offer significant benefits when used appropriately, but that they are associated with higher rates of maternal morbidity and mortality, an increased rate of maternal psychological problems, and higher health care costs (Biringer et al, 2000). The report put out by the Institute for Evaluative Sciences entitled "Caesarean Section Rates in Ontario: An ICES Practical Atlas Update" illustrates the indications for the 19% of caesarean section deliveries in Ontario in 1997/98. The four major reasons for performing caesarean

sections were: previous caesarean section, dystocia, breech presentation, and fetal distress (Anderson & Axcell, 1998 as cited in Biringer et al, 2000). For women with a high-risk labour, whose babies were in distress or in a breech position, it is acknowledged in this report that a caesarean section was likely the preferred method of delivery. For the four hospitals surveyed in the Ontario Women's Health Council report, women who had a previous caesarean section were encouraged to go through a trial of labour and attempt a vaginal delivery, thereby reducing their repeat surgical delivery rate. Also, the definition of dystocia (failure to progress) was altered so that adequate time was given to determine if the baby could be delivered without the need for medical intervention.

It is clear that the hospitals examined in the Ontario Women's Health Council report have a commitment to review policies and practices in an effort to reduce caesarean section rates. This suggests that there is a possibility of a systematic reduction in caesarean section rates if medical professionals as well as the health care system show the same dedication and commitment demonstrated by these four hospitals. The report recommends that the "broader health care system should provide the policy, funding, monitoring, education and research support that will help Ontario hospitals achieve and maintain low caesarean rates throughout the province." (Biringer et al, 2000).

The Impact of Unplanned Caesarean Section

One of the most common major operations in North America is the caesarean section (Flamm, 1989). The World Health Organization (WHO) states that caesarean

rates are medically necessary and beneficial in only 10% to 15% of births (Macleans, June 1999 as cited in Biringer et al, 2000).

Feminist writer Anne Oakley discusses the caesarean section in terms of a surgical procedure:

> ...caesarean sections are referred to in a different way from other forms of abdominal surgery. The very term caesarean 'section' hints at this. We do not call it surgery or an operation or hysterotomy but use the benign term 'section'. This way of conceptualizing the operation is associated with a difference in the way in which the effects of caesarean sections and other surgical procedures are seen. While it is accepted among surgeons that depression is a common consequence of major surgery, the same assumption is not made about a caesarean section. Many of the psychological consequences of surgery in general apply also to caesarean section; including temporary response of emotional relief and elation at having survived the operations, worry about the mutilating effects of the operation on the body, and a long, drawn out period of physical and psychological discomfort. It is worth noting that the kinds of demands that the care of a newborn may make involve activities that are likely to be forbidden to any patient on a surgical ward for days or even weeks after abdominal surgery (Oakley, 1983, p. 104).

The dramatic increase in rates of caesarean deliveries in the 1970's encouraged researchers to determine the emotional impact that this form of childbirth had on women. Much of the research conducted was during the 1980's. Following this period, there seemed to be a drop in interest in this area, possibly due to the belief that women had made gains in the area of childbirth and concern for their emotional well being was not as pronounced. It may also be that as caesarean rates continued to rise, society as whole began to believe that a caesarean section was just another way to have a baby and that women would accept either form of delivery as normal, thereby negating the need for further research.

Much of the research that had been done in this area was from a nursing perspective. Nurse researchers studied the emotional and psychological responses of women who underwent an emergency caesarean section in an effort to better understand and support their patients.

A woman's emotional response to her birthing experience, in part, is shaped by her degree of involvement and sense of control. Loss of control of the labouring woman over the birthing process was identified as a theme in the literature as women felt that they had no role in the event (Affonso, 1980; Marut, 1978; Sandelowski, 1984). Women were left feeling that they could not control their bodies and that they had to relinquish that control to the medical staff. The staff then completed the task, leaving the woman with the sense of loss for not having actively participated in the birth experience (Clement, 2001). A recent study found that a sense of involvement in decision making is important for women (Clement, 2001). Another study also found that a woman's ability to function with control is an important aspect in maintaining self-esteem, and when the mother is "delivered" and passively submits, the positive effect of mastery and accomplishment is absent (Cox, 1982). In addition, the literature suggests that a sense of control over what is being done during labour and delivery is associated with a more positive birth experience, increasing satisfaction and lessening depression (Green, 1990).

A sense of loss associated with childbirth is not restricted to women having delivered via unplanned caesarean section, however, for these women their emotional response is deepened. Anne Oakley (1980) contends that all childbearing women feel some sense of loss in relation to becoming new mothers. Oakley (1980) found that even

'normal' births can involve elements of loss for the mother; loss of self-confidence, loss of body image, and loss of previous employment. The woman having undergone a caesarean section also has to integrate all of these losses with the loss of the experience of childbirth (Oakley, 1980). For a woman having delivered by unplanned caesarean section her loss extends to changes in body functioning, diminished self-esteem as a human being and as a woman in particular, and a lack of self-control and mastery over external events (Sandelowski, 1984).

Women also expressed feelings of failure in relation to the caesarean birth experience. A prerequisite to this sense of failure is the preconceived expectation of the birth process and her role in it. The mother who loses the opportunity to participate actively in the birth of her baby feels that she has failed to achieve her personal goals for labour and delivery (Clement, 2001; Marut, 1978). She may also experience a 'loss of self' as she believes that she has failed to achieve that expected goal (Marut, 1978). Furthermore, the disconnect between achievement and expectation may be critical to the quality of mothering, adding to feelings of failure (Cox, 1982). Marut's study also found that many women having undergone an unplanned caesarean section have a good recollection of their labour plan, but some could not recall details of the actual experience because it did not conform to their expectations (Marut, 1978). Unfortunately, raised expectations for childbirth have created the possibility for women to believe that they have failed at childbirth in the event of a caesarean operation (Sandelowski, 1984). Women who questioned the necessity of the caesarean section were also less likely to be satisfied with their birth experience (Clement, 2001). However, it appears that when

caesarean birth is perceived as a medical necessity, women are less likely to experience feelings of personal failure (Sandelowski, 1984).

High expectations for a satisfying birth experience are also related to social class (Culp, 1989). Green commented:

> (expectations) may be linked to a woman's social class or level of education, for example, the stereotype of the middle-class, well-educated woman for whom the emotional fulfillment of birth is at least as important as the end product. She has read all the books, imagines that she knows exactly what the birth will be like, and expects to be in control. This is probably her first birth, other wise she would know better. When her expectations are inevitably not met, she is devastated (Green, 1990, p. 15).

In contrast, women who are in the lower classes have lower expectations for the birth experience itself and have values more closely aligned with those of mainstream obstetric practice, where medical authority and technology are emphasized (Sandelowski, 1986; Green, 1990).

Self-blame and guilt were also prevalent themes in the literature. Women were found to blame themselves and their bodies for the unplanned caesarean delivery and to be critical of their 'performance' (Cox, 1982). "A caesarean delivery can alter the way a woman feels about herself as a woman and challenge her confidence in her body and its wholeness and normality" (Clement, 2001, p. 118). This self-blame can affect the way the woman views herself, approaches motherhood or plans for a subsequent birth (Ryding, 1998). Guilt also emerged in relation to women's conflicting emotions surrounding the birth of their child. Many women felt negatively toward their birth experience, but the prevalent message in society is that a woman should be grateful for having a healthy child no matter how that child was delivered. Women feel guilt when

their response to their birth experience included feelings of regret, dismay and anger, alongside the joy of having a healthy child (Grace, 1978).

Women also reported negative feelings toward hospital staff. Some felt that they had been violated (Ryding, 1998) and related the notion of being crucified, as a woman is laid on a table with her arms outstretched and strapped down (Affonso, 1980). Others felt that they were not informed about what was going to happen during the caesarean (Affonso, 1980). One study showed that women perceived their situation as extremely hazardous as a result of the information either given or withheld by the medical staff (Affonso, 1980). Women who felt that they had been given the 'right' amount of information were more likely to feel happier about their experience of childbirth (Green, 1990).

Fear was also a prominent theme in the literature. Women expressed fear for their baby, being afraid that they would lose the baby or it would be seriously injured (Ryding, 1998). Others expressed fear that they would die or be harmed physically or mentally (Ryding, 1998). It was also shown that women expressed feelings associated with fear of pain as a result of the caesarean (Affonso, 1980), and not surprisingly, increased feelings of pain were associated with a less satisfying birth experience (Green, 1990).

Perhaps unexpectedly, the natural childbirth movement spawned by the Women's Health Movement is often associated with the distress that many women feel following an unplanned caesarean delivery. The feminist ideal of women's control and mastery over their bodies and their lives encourages women to take responsibility for their health and their care, including their care and involvement during the birthing process

(Sandelowski, 1984). Women who value the natural childbirth movement believe that birth is a natural process that can be accomplished with little or no medical intervention. However, women who embrace these ideas and still end up with a caesarean section can feel that they are incapable of controlling their bodies and have failed their womanly duties to bear a child as nature intended (Marut, 1978; Miovech et al, 1994; Clement, 2001). Women who have high personal expectations for their birth experience are more likely to have feelings of disappointment, loss and guilt following a caesarean section (Sandelowski, 1984).

The greatest need expressed by women was for emotional support. Several women felt that more contact with their spouses, as well as more understanding and encouragement from their physicians and nurses, would have improved the caesarean birth experience (Reichert, 1993). Women also stated that having more information before, during, and after the procedure would have helped them to reconcile their feelings about the birth (Slade, 1993).

Studies suggest that there are marked differences in the experiences of women who have had an unplanned caesarean section as compared to those having planned for a caesarean birth. Planned caesarean sections allow a woman to understand the procedure, go through the feelings of loss prior to the birth, and prepare themselves for the discomfort they will feel (Hillian, 2000). Women may also be afforded the time to discuss the procedure with their obstetrician and make any special requests prior to delivery, such as allowing the father to announce the gender of the child or permitting the mother to hold her baby prior to it being tested for Apgar scores. These requests are

more likely to be honoured during an elective caesarean than an emergency caesarean, as the doctor has been notified of the requests ahead of time and is able to make the necessary arrangements. Women are also more likely to be awake during an elective caesarean section due to the use of regional anesthetic versus general anesthetic. Studies have found that women who are under general anesthetic during delivery have more negative psychological responses to their caesarean delivery as a result of 'missing pieces', parts of their delivery that they are unaware of and cannot reconstruct through memory (Hillian, 2000; Sandelowski, 1984). Increased feelings of loss are also apparent following delivery under general anesthetic as women feel that they have lost the experience of the birth of their child (Clement, 2001). Caesareans under general anesthetic represent the ultimate in loss of control, which may also contribute to women's negative responses to their unplanned caesarean sections (Sandelowski, 1984).

Study Focus

The literature related to women's responses to their unplanned caesarean section is generally consistent in finding that women often view their experience of childbirth by caesarean delivery as unsatisfying. They have feelings of failure, loss and disappointment. The current research study will explore women's feelings about their unplanned caesarean delivery through the use of personal interviews. Participant's expectations of childbirth will be compared with their birth experiences, and their strategies for coping with any negative emotions will be explored.

This work differs from previous studies on this subject in that it only looks at women who self-identified their caesarean delivery as a predominantly negative experience. The participants recruited for this study had all expressed a need to discuss their caesarean birth experience with like-minded women through a community support group, and were motivated to continue to be active participants in the group years after their unplanned caesarean section. At the time of the interviews all of the women had received informal education with respect to various aspects of the birth process, and information and preparation for subsequent vaginal births after caesarean (VBAC) deliveries. The women chosen for this study all expressed a need to have their voices presented to a larger population and to that end were willing to be open and honest about their birth stories.

All of the research presented above studied the effects of unplanned caesarean deliveries from a nursing perspective; as a result, no previous studies have looked at the way that social work services may benefit women having had this experience. It is my hope that the information acquired through this study will help professional social workers who interact with this population of women to be more informed about their special needs, and to be better able to offer effective support.

METHODOLOGY AND STUDY LIMITATIONS

Research Design

A qualitative research design was utilized in this study. The participants attended personal interviews and were asked a series of open-ended questions pertaining to their experiences surrounding their unplanned caesarean section. By using a qualitative approach, the women were able to discuss what was most relevant to them, allowing for the free flow of information. The analysis of the qualitative data made it possible to identify both common and unique themes that emerged from the interviews.

The use of interviews is in keeping with a feminist methodological framework for research and allows space for alternative voices to be heard as feminist research considers a woman's voice as expert on her own experiences (Neysmith, 1995). Feminist methodologies allow the researcher to provide an explanation of the purpose of the research, the assumptions underlying it, what experience the researcher has had in the area, and an opportunity for participants to offer further information not specifically requested. This study sought to follow a feminist methodological approach to research. As the researcher, I ensured that all participants understood the nature of the study and were aware of my own personal experience with an unplanned caesarean section. I also attempted to be inclusive of participants in the formulation of the research questions by asking for input and feedback at the end of the interview process.

Sample

Five mothers who had undergone unplanned caesarean sections were interviewed. The women were between 26 and 36 years of age at the time of their caesarean section. All five women were Caucasian, identified themselves as Canadian and resided within a 30 kilometer radius of one another. All five were married at the time of the births and described themselves as having supportive partners. All had received a post-secondary educational degree or diploma. None of the women had any significant financial constraints, and none who had been working prior to the birth of their child felt pressure to shorten their maternity leave as a result of their financial situation. For four of the women, their caesarean birth experience was also their first birth experience. These four women had subsequent vaginal births. The fifth woman had had a previous planned caesarean delivery for her first child as a result of breach presentation and an unplanned caesarean section following a trial of labour for her second child.

Participants were recruited through a support group for women who have undergone caesarean sections, indicating a non-probability, purposive selective sample. I attended a meeting of this group after obtaining prior consent from the chairperson and presented to the members the purpose of the research. Interested women were asked to approach me for further information or clarification. Five women agreed to participate in a one-time interview. Four of the women were long-time members of the group while the fifth was a guest speaker who had also undergone an unplanned caesarean section for the birth of her first child.

Participants for the study were chosen from this support group as they were perceived as being likely to provide a different view of caesarean sections than would the majority of mainstream women, due to their active efforts of self-education and group counseling after the birth. These women have also had access to support and education as a result of their involvement with this community awareness group and were able to discuss private and emotional issues surrounding their caesarean section because they had the opportunity for similar disclosures within the safety of this support group. These women offered an acute and informed account of their childbirth experience as a result of their immersion in the issues related to the birth.

Procedure and Study Focus

A one–time semi-structured interview was conducted with each participant using an interview guide (See Appendix A). Prior to the interview, participants were provided with a Letter of Information (See Appendix B) that outlined the purpose of the study, informed them of their right to withdraw at any time, and explained that confidentiality would be maintained. Participants were also asked to sign a consent form stating that they understood the purpose of the study, their right to withdraw, and the confidentiality of the data (See Appendix C).

The interviews lasted between forty-five minutes and two hours, were carried out in person, and were audio-taped. Participants were asked to tell the story of their unplanned caesarean section, to discuss their expectations of the birth, where their expectations may have come from, how they felt about their caesarean then and their

feelings now, and what has helped or hindered their ability to cope with their experience. Participants were also asked if they felt they would have benefited from having a professional to speak with about the feelings associated with their unplanned caesarean birth.

All five interviews were tape-recorded and transcribed verbatim. The responses provided by the participants were analyzed for common themes and patterns. Once the themes were clear, the data was further analyzed into sub-categories. The themes and their sub-categories were checked by my supervisor to ensure that interviewer bias was not affecting my judgment surrounding the content of the data.

For the purpose of this study, I was interested in how the women told the story of their caesarean section and the emotional responses they experienced following the birth. I wondered if particular expectations of the birth played a part in how women viewed their experience and if greater expectations for a non-invasive birth had led to greater emotional upset. I was also interested in knowing how the women viewed their relationship with the medical staff and their feelings surrounding their medical treatment. As women in this study all had emotional responses to their caesarean sections that led them to seek out and attend a support group, I was interested in determining what factors, the support group included, helped them to cope with their experience and to recover from it. Finally, it was of interest to me to know if these women would have used the supportive services offered by a professional, such as a social worker, to help them make sense of their experience, had such service been offered.

Limitations of the Study

The most significant limitation to this study is the sample itself. Participants were recruited from a community self-help support group, which indicates their motivation to seek out like minded women and to help themselves deal with their reactions and feelings related to their unplanned caesarean sections. All the women interviewed had strong negative feelings associated with their caesarean section and, prior to joining the support group, felt that they were alone in their conflicting feelings of having a healthy child but a disappointing birth experience. Although generalizability is not a primary goal of qualitative research, the results of this study are limited to women who have viewed their unplanned caesarean section as a predominantly negative experience. Therefore the findings cannot be applied to women who felt that a caesarean section was necessary and best for both their baby and themselves.

This study is also limited by its small sample size. While rich and descriptive information is gained through the use of open-ended questions, saturation is unlikely to occur with a sample of five participants. Small sample sizes limit the likelihood of discovering the majority of issues associated with having an unplanned caesarean section. The limited sample size of this study also means that the study cannot address issues pertaining to race, ethnicity, socio-economic status or education level. Further research that considers these demographics needs to be conducted in order to gain a better understanding of how unplanned caesarean deliveries are viewed by the greater population.

This study is further limited by the fact that it was based on recollection alone. When the women agreed to participation in the study, they were told that they would be asked about their caesarean experience and the feelings that surrounded that event. At the time the interviews were conducted, the range of time that had passed since the caesarean section was between two and a half years to six and a half years. During the interviews, all of the women made reference to not being able to recall how a particular part of the event unfolded. This can partly be attributed to the lapse of time between the caesarean section and the interview, and also to the fact that some women may have blocked out particular stresses related to the event in an effort to cope. During the interviews, all of the women struggled emotionally and four of the five needed time to collect themselves after crying. Another explanation for their inability to recall details may be the sometimes hectic nature of events surrounding an emergency c-section, making it difficult to keep track of everything that had happened.

It became apparent through the interview process that there were many reasons why women experienced their unplanned caesarean negatively. It was not possible to specifically explore all of these factors with the participants and therefore further research is needed. As well, given the vast amount of information was gathered through the interviews, it would be impossible to identify and discuss each issue within the time constraints of this study.

It is important to note that my interest in this topic stemmed from my own traumatic experience of an unplanned caesarean section. The challenge in looking at qualitative data when you have had a similar experience to those interviewed is that it is

sometimes difficult to separate yourself from the experiences of the participants. It is my belief that through concerted efforts, I have been able to present the data so that they are relatively free of personal distortion. However, I would argue that in having an experience similar to my participants, I was better able to detect the subtleties that emerged as the women told their stories. Also, my study may have benefited from the common experience because the participants may have felt more at easy and therefore, more likely to share difficult details.

While these limitations cannot be ignored, and it is evident that further in-depth research is warranted, the information gathered from the interviews and the themes that emerged as a result of the data analysis can be of immediate value to professionals who seek to understand and support women who have undergone unplanned caesarean sections.

IN WOMEN'S WORDS: A NARRATIVE REVIEW OF THE FINDINGS

As a researcher I felt privileged to listen to the participants tell the story of their caesarean birth experience. These five women were passionate about their experience and perceived the unplanned caesarean as a life-altering event. Many shed tears while telling their story, even though for some of them of the caesarean section had been more than six years ago. All of the women have dedicated some part of their lives to providing support and education to new mothers about the birthing process, or to women who have had a caesarean section and are having a difficult time assimilating the experience into their lives. It is my hope that I can do justice to their words when presenting the themes that emerged as a result of my research questions, and that the analysis facilitates a deeper understanding of what this experience can mean for some women.

An Emotional Reaction

Participants in this study expressed a variety of emotions when telling the stories of their caesarean sections. They were not asked specifically how they felt about their caesarean experience or what feelings they had in relation to that experience, but the women in this study readily volunteered the information when describing the often negatively charged emotions they had during labour, delivery and following the birth of their children. This section will provide a summary of the feelings expressed by these

women, which included fear, self-blame, inadequacy, failure, anger, isolation, loss, and guilt.

These women describe feeling fear in relation to the experience of their unplanned caesarean section. Some women had a fear of the unknown. They had never been in an operating room before and were unsure as to what would happen when they got there. Explanations of procedures were not readily provided by medical staff, contributing to the sense of fear that the participants experienced.

Fear for their well-being was also prevalent. One woman described being fearful for her life because she could feel the incision being made. Post-operatively, this same woman stated that she was terrified because of the pain she had felt at the time of the operation. This feeling of fear is still tangible years after the initial surgery. Upon entering the hospital for a very minor procedure four years after her caesarean section the woman felt a sense of panic:

> *I went for surgery...and I remember lying down on the table with this big light on and the doctor giving me freezing and telling me that he would leave the room while it took effect. And I started to panic. I'm lying there and I started thinking "Oh my God! What if I can feel it?"...But I was having flashbacks...and I'm thinking, "Okay, he's coming back with a knife in his hand to cut, cut me." So I don't know if you ever get over it.*

Another woman's fears were focused on her incision, as it represented the apprehension and panic that she had felt:

> *I was crying and the nurse came in and I said "I'm scared and I'm scared of my scar and I don't want to see it and..." And she said "It's all healed." And I said "No. No I don't think it is. I can feel it."*

Two women described fearing for their baby's health. One woman was told that her baby's head was being "crushed" by her pelvis and that a caesarean section had to

performed in order to ensure the well-being of her baby, however, following the birth she was not told if the baby had been injured during the labour.

> *So I remember they started cutting and they pulled, they pulled the baby out and I just remember seeing her go from me to over there...and I remember her head...and she had lots of hair and it was full of like blood and stuff and like dripping and I remember thinking, "Oh my gosh. Her brain is crushed..." And I remember saying to my husband, "Oh my gosh! Look at her head!"*

Whatever the focus, fear is reported as a dominant, often overwhelming negative reaction to an unplanned caesarean delivery, and was clearly still prominent at the time of the interviews.

Some of the women interviewed also blamed themselves for the outcome of a caesarean section. Three women felt that they had not educated themselves enough about different aspects of birth, such as the impact of certain medical interventions on the progress of labour, and all women berated themselves for not preparing themselves for the fact that many labours result in caesarean deliveries. Another woman felt that she should have attempted to find out more about one of her health care providers, a midwife, who had attended her birth.

> *For some weird reason, I thought because she was (of a different cultural background), that she was one of those old midwives who had come from (a different country), who had been doing it for years over there. And I guess I never checked... I thought she was from the old school and that she had come over here. I think that later I found out that she was kind of new at it and she had trained in Canada. Now what kind of idiot am I for not checking properly?*

One woman was convinced that she was responsible for the caesarean section because she had gone into labour on the weekend and her obstetrician who had been caring for her prenatally does not deliver babies on the weekend. Two women felt that they should

have been more assertive with respect to their care and the final decision to perform a caesarean section, and blamed themselves for lacking the confidence to speak up. For one woman it was planning a second birth that caused her to question how her first birth had unfolded, and as a result she began to blame herself for not being able to prevent the caesarean by questioning the medical decisions that were made. Coupled with the need to blame themselves for the outcome of the birth, four of the five women interviewed described feelings of failure. Two of them associated this feeling with the socially propagated view that to give 'birth' is to do so vaginally:

> *I've had a few people tell me, "You know, you're not a woman unless you've had a vaginal birth."*

All women stated that most of their female relatives had vaginal births and described the fact that they did not deliver their babies vaginally as an indication of failure. The women's sense of failure was primarily attributed to the feeling that they were not well prepared for the possibility of a caesarean section, implying that they are at fault because they did not educate themselves prior to the birth.

Feelings of inadequacy were also identified by many of the participants. Three women had directed their husbands to follow the baby to the nursery because they were unable to do it themselves, since they were still being stitched up after the caesarean, making them feel that they were unable to follow the instinct to protect their baby. Another woman felt that she was unable to adequately care for her child because of her own discomfort and pain.

> *So, I'm lying there in this bed and she starts to cry, to be fed, and I'm lying there in this bed and I just couldn't get out of this bed.*

This same woman developed a serious infection soon after delivery, further preventing her from caring for her newborn, adding to her feelings of inadequacy. Two women described feeling inadequate because they were relying on medication when they should have been able to handle the discomfort without it. One woman said that it took her two weeks before she could get through a day without medication, while another woman described feeling like an addict.

> *I remember the nurse standing over me and she had a needle in her pocket full of morphine and she said to me, "If you feel any pain let me know and I can give you a shot." And I remember thinking, "Give me drugs!" I felt like I was an addict... Like, "Give it to me, give it all to me!"*

Many of the women stated that feelings of inadequacy persist to this day when they recount their childbirth experiences.

All women interviewed expressed some form of anger. Some were angry at themselves for not being better informed about the procedures and processes involved with a hospital birth, while others were angry at their health care providers for the way they felt they were treated.

> *I look back on it and I feel more anger and you know, about how people, how professionals could have treated the situation. How I could have educated myself better.*

One woman openly expressed her anger at her newborn saying,

> *I'm looking at her, and I'm just looking at the baby and "You've caused me some pain. You've caused me...all this trouble... This is your fault!"*

Two other women described feeling disassociated and detached from their baby, possibly as a result of subconscious anger they were feeling toward them.

> *I felt nothing when they showed me the baby.*

> *I'm totally disconnected. It could have been a doll. It could have been someone else's. There was obviously no connection there. It was just such a detached feeling... I did not want to hold her or touch her the entire day.*

Although these women initially expressed some anger and detachment from their baby, these feelings did not last long and did not appear to interrupt mother-infant bonding.

Feelings of isolation were also apparent through many of the interviews. Women described feeling alone in their emotions, that no one understood why they were feeling sad or disappointed when they had just had a healthy baby. One woman wrote in her journal shortly after the birth of her child. She described not understanding why she was having negative feelings about her caesarean section and believed that she should not be feeling that way.

> *I wish I could just get over it. You know, forget about it. You know, get on with life. I know I shouldn't be dwelling on it. It's just that I can't seem to help it. Like no one understands how I feel.*

She went on to later say,

> *I had no one to talk to about it. Everyone was like, "you had a healthy baby, so what's your problem?" So I had no one who had experienced it. No one who had gone through it ... none who had a similar experience.*

One woman who had been a part of the community awareness group prior to her unplanned caesarean section took some solace in the fact that she could go back to the women in that group and speak to them about her feelings associated with this birth knowing that she would be heard and supported. Another woman used silence as a method of coping and felt that she could not talk about the birth. She felt that because it was such a traumatic experience for her, she did not want to discuss it with others for fear of reliving the painful emotions associated with it.

One woman was put under general anaesthetic for the delivery of her baby as a result of complications with the epidural. She felt isolated because she believed that her baby's birth was not celebrated at the time of delivery as there was no one in the operating room who had a personal connection to this newborn.

When it's just the medical people around, it's just another birth.

Another woman described feeling isolated in her emotions because caesarean sections are often viewed as a 'normal' means of birth and to talk about it with others would be to admit that she was somehow abnormal and deviant.

All women stated that they experienced some form of loss that resulted in feelings of grief. This was usually associated with the loss of a vaginal birth and the sense that they had missed the opportunity for a 'proper' birth. One woman believed that having a caesarean section was not normal. Two women did not feel that the caesarean section was equated with giving birth:

> *...there was just something in me that wanted to experience the actual giving birth, because to me even though I had the baby, having the caesarean didn't feel like I had given birth. I felt like that option had been taken away from me... I didn't give birth. It was taken out of me. I didn't give birth.*

> *With a c-section there are real feelings that you never gave birth and I don't know if you ever get over that... They are mine and I love them. I created them, but I didn't see that last little bit. I didn't bring them into the world. It's like somebody else got to them before. So I didn't give birth to them.*

One woman's sense of loss is associated with the fact that she was under general anaesthetic during delivery. She describes grieving the loss of her birth experience and that the feeling of grief and loss will be with her always, because no matter how many subsequent births a person has, none of them can make up for the loss of that one.

I still feel like I missed out and regretful that I can't change it 'cause there's absolutely nothing I can do to change that...You grieve, you've lost something... There will be that sense of grief and loss. And that's why I think that you can't expect other births to make up for that, because you can't make up for that.

Two women discussed feelings of guilt during their interview. One woman had faithfully written in her journal prior to the birth, but did not write any entries following the delivery because she did not want her child to ever read the journal and feel badly that her mother had such strong emotions related to her birth.

...and from when I delivered on, I wrote nothing. It's all blank. I've got nothing written. So one day I will write in it... 'cause I didn't want to write in all those negative thoughts, because it would have been all those negative, horrible thoughts and I didn't want my daughter to read that...but I won't ever tell her what I went through 'cause I don't want her to think, "my mom didn't want me, and my mom had this horrible section because of me"

Similarly, another woman expressed some fear of her children reading this study because she did not want them to think that she did not want them or love them as a result of the delivery.

All women agreed that the experience of their unplanned caesarean section was a life altering event. They believed that while the experience was unpleasant and traumatic, it changed the person they were and made them think a lot about themselves.

Ultimately, I am thankful for the experience. I think that I did grow from it.

I feel though, that in some ways it was altering. I feel I can help other people because of what I have gone through. So, I feel in some sense, fortunate that I have experienced something that I was able to deal with to some extent.

The emotions that arose within these women following their experience of an unplanned caesarean section were strong and pervasive. These women continue to carry feelings of failure, loss and trauma with them years later. One woman wrote an entry in her journal

a few weeks following her caesarean delivery that summed up how many of the women felt about their caesarean experience:

> *I felt like crying all the time. I felt like a failure. Unable to do anything, a complainer... I know I kept saying, "Whatever is best for the baby is the most important thing", but I wanted to scream not to slice me open. I wanted to beg them to wait a little longer. I just wanted a normal, regular birth. I wanted to share in that moment when baby was born. That beautiful bonding moment when baby is held by parent, tears of joy. A moment like no other, to be remembered for a lifetime. And that was stolen from me.*

Relationship with Care Providers

The women's perceptions of the medical professionals involved were as varied as their individual emotional responses to the birth. Some women felt supported by a few of the medical professionals, while those same women felt berated by others, describing the staff as callous and uncaring. However, all of the women interviewed remembered their treatment by medical staff, whether good or bad, as being an important factor in their recovery. This section of the findings will examine the participants' perceptions of medical staff and their perceptions of themselves in relation to the medical professionals who provided their care.

Two women interviewed found the nursing staff encouraging and supportive. These nurses made requests to the doctor on behalf of the women, particularly in requesting that the woman be allowed to labour for a while longer before the final decision to perform a caesarean was made. Another woman found that while the nursing staff appeared supportive, they seemed fearful of the doctor on call and she perceived their comforting gestures as an effort to keep her quiet so as to not provoke anger from the doctor.

> *...and she kept saying, "shush, shush, just keep quiet", and she was rubbing my arm, "shush, shush, just be quiet"...and shushing me. Like "don't ask the doctor questions, he knows what he is doing..."*

Another woman did not feel that she had received any real assistance from the nursing staff. While they were not outwardly discouraging, neither were they supportive.

> *...not a lot of help from the nurses... They weren't bad, they weren't good. They were just indifferent.*

One woman felt that her doula and midwife were not able to support her in the way that she needed. She felt that the reason she had chosen to be cared for by alternative caregivers was for the more personal approach and the fact that they would be there to assist and encourage her through the whole process.

> *My midwife was not fully supporting me...No one was jumping in and helping me. I was on my own. Like, the doula is standing there and the midwife is standing there...I was thinking, "when are people going to realize that I need help?" I felt like I was directing the show...Well, they were all like 'lalala", like so stupid, right. They were standing there and not doing anything.*

This woman ultimately felt deserted by her chosen caregivers, believing that she could not ask them for any additional support. This was particularly disheartening because she did not see herself as a passive person, and behaving that way during labour caused her further distress.

While apathy on the part of caregivers was noted by some women, two women interviewed felt that the doctors on call were unkind and uncaring. One woman was told that her baby was in distress and that they needed to get her out. While waiting for the epidural anaesthetic, she continued to have contractions which made her curl up in a ball. The doctor became angry with her:

> *"Keep your legs open. You have to keep your legs open!" And at one point he said, "Would you keep your damn legs open. If you can't take the pain, you shouldn't have gotten pregnant!" And I remember thinking, "Oh my God." and of course I started crying...*

The other woman felt that because she was asking questions of the obstetrician on call she was labelled as difficult. She overheard the obstetrician telling another doctor that she felt that the woman and her family were questioning her medical authority. This woman also refused the obstetrician's request to allow a student to perform a vaginal exam, frustrating the obstetrician to the point where she accused this woman of being more concerned for her own comfort than the safety of her unborn baby.

Four of the five women felt that the medical staff did not provide them with sufficient or even accurate information. These women believed that they could not request additional information because they were not entitled to question medical professionals since they are the experts who "know" what they are doing.

> *They didn't explain to me...nobody explained to me...The nurses weren't explaining themselves. They weren't explaining what I was feeling. As far as I knew I had to, I did what the doctors told me to do... I think I looked up to professionals. Put a lot of trust in the OB's and nurses...*

One woman had the obstetrician refuse to give her any information during a crisis situation saying that she had work to do and did not have time to explain what was happening. Two women were given medication that made them nauseous, but were not told that this was going to happen or what the effects of the medication on the baby would be.

One woman reported that the anaesthetist insisted that she was well frozen and could not feel the cut even though she had clearly stated that she felt the incision.

...he went to cut because the anaesthetist said, "Oh, she's fine. Go ahead." And when he went to cut...I screamed out, "I can feel it! Stop cutting!" And the anaesthetist said, "Oh she's just saying that but she doesn't really know what's going on, so just go ahead with it."

Two women were given the impression by the medical staff that they wanted the birth to be over quickly and the best way to accomplish that was by performing a caesarean section.

You know, it really almost felt like, you know, they don't really want this to go beyond midnight, shift change or something like that...so there were a couple of doctors in the room, you know pushing us, so we decided to go for it.

One doctor was more overt in his desire to 'get things over with':

And I remember his cell phone rang. He picked up, "Yeah, I've got two down, three more to go." And I'm thinking 'three more to go? What does that mean?' He said, "Yeah, I got the beer, do you have the steaks?" He said, "Give me an hour and I'll be out of here."

The treatment that these women received from the medical professionals left them feeling invisible. Clearly, their needs were not met. Their voices were not heard. The women were made to feel non-compliant if their behaviour was not in line with the doctors' wishes. They were made to feel unworthy of explanations regarding their own treatment. They felt pressure to make decisions while in pain and under time constraints, and felt that they had no choice but to heed the doctors' recommendations because they were the 'experts' who could provide the 'best' outcome for their baby.

All of these women clearly said that should such a situation arise again, they would not be so afraid to ask the questions or to even challenge a medical decision if it was not in line with what they believed to be necessary at the time. They believe that through attending the support group they have learned about patient rights, and all

expressed a hope that because of new-found inner strength, they could speak up and protect themselves and their newborn infants should the need occur.

Relationship with Supporters

All of the women interviewed had support people with them, such as their husband or mother, during labour and delivery. While most of the women's accounts of their unplanned caesarean sections focused on their own feelings and experience of that event, they also spoke about their support people and their interaction with them during the birth. Support people approached the event with fear and felt traumatized. In one case, the father embraced the caesarean birth as an unexpected opportunity to bond with his new baby while the mother was recovering. For the most part, the women felt encouraged by their support people, but also realized that their supporters were just as uninformed about the birthing process as they were. This section will report what these women said about their support people during their unplanned caesarean section.

Two of the women reported that their husbands showed fear on their faces during their preparation for surgery. While they would stroke their wives' arms and offer words of comfort, the women knew that each husband was fearful for her well-being.

> *He looked scared...and he sat right there...and the look on his face...he was so scared...he didn't know what was going on. He thought we were going to the hospital to have a baby, come home...*

Two husbands appeared to be torn in their loyalties between the wife they have known and loved for years and the new baby who has just entered the world and with whom have not yet established a relationship. Two other husbands had to be told by their

wives to follow the baby to the nursery as they were unsure whether they should leave her unsupported in the operating room. One husband openly told his wife that if it came to a choice between her and the baby, he would choose her.

> *I remember him saying, not that he hoped the baby would die over me, but he felt that he knew me and loved me and he really didn't have much of a connection with this baby and he had more concern for my welfare than for the baby's. He was more concerned for me than for the baby.*

All of the women described their support people as equally powerless with respect to dealing with the medical staff as they were.

> *Not that my husband wasn't helpful, but he was just as ignorant about certain things as I was, even though he was supportive*

Each woman noted that she had attended a support group prior to their subsequent births and felt more empowered as a result. In future deliveries, they expressed the belief that they would be better able to advocate for themselves than their husbands would be.

One woman described her husband's feelings of satisfaction at his wife having had a caesarean delivery because he felt that it opened the opportunity for him to spend more time with his newborn than he would have been able to if his wife had delivered vaginally.

> *I mean despite the surgery part, he enjoyed the c-section part because he got to spend all the time with the baby. He bonded a lot with (baby) when she was an infant, 'cause he got to hold her more and he got to get her to the nursery and do all that stuff and feel really important, involved.*

She described feeling that since she had a difficult time managing her emotions concerning the delivery, she did not mind her husband taking an active role in the parenting of their child.

Three women stated that their husbands did not fully understand the emotional impact the caesarean delivery had on them, and while none were described as denying that their wives had difficulty coping with the experience, none were able to provide the kind of support that each woman felt she needed.

> *Only a couple of years ago did he come to realize the impact the caesarean had on me. I don't think he ever fully understood how awful it was for me.*

One woman clearly stated that she could not talk about her feelings with her husband but knew that she could receive the help she needed from the support group.

> *I remember we got out of the hospital and by that point I was so upset, and I remember I was telling my husband about it and I was, like you know, bawling as we were leaving the hospital, and, you know, I guess husbands, you know men, have other issues...and he got so mad at me. So I thought 'Okay. He's not the guy to talk about this with. I'm going back to my VBAC meeting'.*

Another woman felt that having a doula with her for her second birth would be beneficial because although her husband was supportive in many ways, he was not able to understand the feelings she had surrounding her caesarean delivery.

Many women felt that they had to be strong for their support people; they in essence became the supporters of their supporters. One woman felt that she had to reassure her husband that things were going okay, although what she really needed at that time was reassurance from him.

> *So he left and I remember when he came back feeling like I had to sort of reassure him that things were okay.*

> *I was feeling like I was giving him more support. I felt that I would rather have (someone else) support me rather than me having to calm him down.*

Women also reported wanting to please their support people and not wanting to disappoint them. When one couple was told that their baby was a girl, the mother looked to her husband and asked if that was okay. Another woman felt that she needed to practice a particular form of relaxation because her mother believed very strongly in it and she did not want to disappoint her.

> *And my mom had this idea that if I could just relax my hand that that would help. She was such a firm believer in that I felt that I couldn't disappoint her.*

One woman was upset and angry at her family members because they failed to notice that she was having a difficult time coping with her caesarean birth experience. She felt that if they loved her, they should have been able to see that she needed help and to do what was necessary.

> *And I remember talking incessantly about it with my midwife, my mother, my husband. Sort of calling out and feeling like I need help and maybe if I couldn't help myself, someone could have helped me by saying "I hear you and I've found these resources" ... And so it was like I needed somebody to say "Yeah, I think you'd benefit from this and here let me help you find someone." That's what I think I was looking for. Because the people that I was surrounded with who were very supportive in a lot of ways, they just weren't able to take that step.*

She clearly felt let down by those people upon whom she relied the most.

Several of the women felt that their husbands did not truly understand their difficulty with the caesarean delivery, even though they had felt supported during the birth. Many women felt that they could not fully express their conflicting emotions to their husbands and be truly understood. For these women, the support of a community group of like-minded women helped them on the road to recovery and helped improve

their ability to more effectively discuss their feelings about the experience with those who love them.

The Expectation-Reality Gap

For women having undergone an unplanned caesarean section, the difference between their expectation and the reality of the birth experience is often what causes them the greatest inner turmoil. None of the women in this study had anticipated a caesarean section; one had actually planned for a homebirth, essentially the opposite of caesarean delivery. While many of the women did not have specific ideas of how the birth would unfold, all believed that they could give birth vaginally. The women formulated their perceptions of what birth should be like based on information from female relatives, television, and prenatal classes and believed that caesarean sections were rare and only used in life threatening situations. This section will examine the factors that informed women's expectations of their birth experience and will look at the gaps between those expectations and the eventual outcome.

All of the women said that they did not know what to expect when they went to the hospital to deliver their babies, other than the popularized notions of birth. They believed that there would be pain, but that at the end of it all they would push their baby out with the support of their husbands and the medical staff. Two women said that their only experience with birth was from television.

> *I wanted to um...feel good afterwards and be able to, I don't know. I think it was like a big rosy picture. I thought I was going to, you know, sort of what happens on T.V.*

Some women's expectations for birth came from prenatal classes. They were taught about the different options available to them at the birthing centre, such as a squatting bar, and assured that there would be supportive nurses on hand to assist them. All of the women admitted to not paying attention during class when the instructor spoke about caesarean sections, because none believed that there was a high possibility of it happening to them.

> *As far as really thinking about it, I didn't give it any more thought than what was mentioned in prenatal classes.*

One woman felt that her labour would be long and difficult because her mother's labours had been that way, and she felt that she and her mother were alike in many other ways. She expected to deliver in a hospital and to be given pain medication quickly, but she did not anticipate having a caesarean delivery, as it was not in keeping with her relatives' birth experiences.

> *The thought never really crossed my mind that I would have a c-section. I think I thought that 'cause I am so much like my mom and so close to her that I would have the same births as she. She never had c-sections, but she had long, difficult labours. So that was the sort of thing I expected to experience. But never a c-section.*

Two women described being informed about the birthing process through popular books and parenting magazines. After their birth experience, they both agreed that these forms of media are no more informative as to the real progression of birth than are television shows.

One woman was strongly influenced by her own work as a medical professional. She had travelled the world and witnessed the suffering of people who did not have

access to medical interventions and felt that the hospital afforded her a safe place to have her baby. Her greatest trauma was the use of general aesthetic during the delivery.

> *I do believe the biggest trauma to me was... I think that if I had had an unplanned caesarean section with an epidural that worked, I don't think I would have felt the way I did. I think that what really made it traumatic was having to have it under general and all that. Definitely.*

For the woman who had planned a homebirth, a caesarean section was about as far as she could get from her expected outcome of the birth. She had enlisted the help of a doula and a midwife and had planned to give birth at home in a tub of warm water. She had her first child by caesarean section, and her expectations for her second birth were informed by listening to other women's accounts of their homebirth and believing that if other women could give birth at home after having had a caesarean section, then so could she.

For all of these women, their expectations of the birth experience did not match with their reality. All of the women went into the birth feeling that this was a natural process and that they could achieve what hundreds of millions of women had done before them. None expected to become a statistic, being the one in five women who delivers her baby by caesarean section. What all of these women realized after this birth experience is that no two births are the same. Circumstances are different for everyone and every body is unique. All of the women felt that they needed to be better informed with respect to the realities of birth and the variety of situations that could arise so that they would be better prepared to deal with the many challenges should they have to face them again.

Bridging the Gap and Healing the Spirit

One of the unique qualities of this group of women was that they all believed that they had managed to cope with their traumatic experience. For four of the women, a community support and awareness group was paramount in their healing. The other woman said she initially found her support elsewhere, but was grateful for the opportunity to talk about her experience when she attended the support group as a guest speaker. Subsequent vaginal births were also a key to these women's recoveries. These birth experiences provided them with a sense of accomplishment and a renewed faith in their bodies' natural abilities. This section will briefly describe women's strategies for coping and what that has meant to their ability to heal the emotional scars of their caesarean delivery.

As mentioned above, four participants in this study were active members in a community caesarean support and awareness group. This group provided women with the opportunity to hear other women's birth stories, gave them a forum to tell their own stories, and provided information pertaining to the birth process and its management. All members of this group attribute their ability to 'move on' to their involvement with this group. All women felt supported by other members and were grateful for the genuine empathy they received. One woman appreciated the fact that she could tell her story without fear of being judged by others for mistakes she may have made.

> *I enjoy being in the group. I can express myself openly and it's a safe place. They won't judge you, you know?*

Two women appreciated the knowledge they gained from the group, from the guest speakers, and also from members who were doulas and midwives. All four women

believed that the most important thing that they learned from being part of the group was that they have rights and did not have to be passive participants in the birth. They can refuse intrusive treatment and could challenge the conventional medical management of birth if is not in keeping with what they wanted.

> *I have the right to speak up. And if I'm ever in that situation again... Like with my second child I refused the I.V., I refused the gown, I refused to lie on the bed. I knew I had the right. Like with my first child, I didn't speak. I didn't know I had the right to speak, to open my mouth.*

While all of the women gained this new found knowledge, they also had a renewed appreciation for the necessity of medicine's involvement in the birthing process when deemed necessary.

The woman who was not an active member of the support group believed that her birth experience had been out of her control. Acknowledging this belief was the key to her ability to let go of the negative feelings. She had read that there are many aspects of birth that cannot be controlled: when labour is going to start, how big the baby will be, or how well the mother will manage the pain. She believed that no matter how much she tried to manage the situation, there were too many factors over which she had no control.

> *Looking back on it, there's nothing I could have done different. So it had nothing to do with me. It all happened to me. You know, all these things happen for a reason, decisions are made, but I actually did nothing to cause that.*

Three of the women felt that their subsequent vaginal births helped them to recover from their negative feelings associated with their caesarean sections. While the second birth could not replace what was lost in the first experience, the vaginal birth restored the belief that their bodies were capable of miracles and that they had the inner

strength and resolve to bring a new life into the world. One woman described feeling like "Rocky" following her vaginal birth.

One woman whose unplanned caesarean section followed a planned caesarean section coped with her feelings by actively participating in the birth of her sister's child. She encouraged her sister to educate herself on all aspects of birth, and she sat with her sister afterward and asked for every detail from the start of labour to the delivery of the placenta. She then wrote the story out and presented it to her sister and brother-in-law the following day. This woman believed that although she could not have the birth experience she desired, the next best thing was to help her sister give birth as free of emotional trauma as possible.

> *I felt that it was very therapeutic for me to actually go through her birth story. I felt now like I lived that story. You know, so I actually felt like I had a VBAC.*

While it is apparent that the support group facilitated the women's recovery from their traumatic birth experiences, it is also evident that the women themselves had great resolve, being able to manage the challenges of new motherhood alongside the variety of negative emotions surrounding the birth of their children.

All of the women feel that they have adequately recovered from their experiences, but all reported that they would have appreciated the opportunity to speak to a professional about their emotional responses to the birth. The support group and family were sufficient at the time, but all of the women believed that they could have benefited from a professional counsellor who could have directed them to the support structures that they needed.

DISCUSSION

A Summary of the Findings

The data received from the women interviewed indicates that women who have undergone an unplanned caesarean section can have intense negative feelings in response to the event. They experienced fear, disappointment, loss of control and a sense of failure. They also felt that medical personnel, for the most part, could not support their unique needs and in many cases were dismissive of, or ignorant about, their emotional responses. None of the women interviewed expressed feelings of appreciation toward the medical staff for having rescued themselves and their babies from impending doom. Two of them even felt that the medical staff were acting in their own best interests, and that performing a caesarean section was the best way to accelerate the birth so that staff could move on to other things.

The women interviewed reported being very disappointed in themselves for not being better educated about all possible progressions of the birthing process. They berated themselves for not being able to take a more active role in the birth of their children, feeling that if they had more knowledge, then they would have been in a better position to challenge the medical staff and could potentially have avoided a caesarean section. They further reported that they did not have any well-defined expectations for the birth experience, but when asked, they all stated that they believed they would have a

'normal' vaginal birth. This gap between expectation and reality resulted in significant emotional trauma.

Participants stated that they felt the support and love of their partners during the birth, but were acutely aware that their partners could not fully understand and appreciate their emotional responses, and the overriding sense of responsibility and failure they felt. A community support organization helped them to cope with the caesarean section. The support they received from other women who had gone through similar experiences helped these women to understand their own experiences, and to plan for subsequent births with a sense of hope.

Although no one explicitly described the feeling, it was clear from their stories that the women interviewed felt a sense of vulnerability. This is, of course, part of giving birth, where a woman must surrender to her body and trust in the people around her. They are nearly naked in front of a group of strangers, which is never easy. Some of the women felt that they were not able to make thoughtful decisions because of the natural state of stress that childbirth causes. They also believed that they were not provided with adequate factual information at the time that those decisions had to be made, leaving them feeling reliant on the decisions of others, particularly the medical staff. The lack of control over, as one woman described it, "an uncontrollable situation", led to a vulnerable and, for some, a frightening state.

Current Caregiver Practice

The rhetoric from many birthing centres and obstetrical practices suggests a model of patient-centred care. Women are led to believe that they are a direct participant in the birthing process and the decision making surrounding that process, and that practitioners will follow the parents' lead. This is not difficult for women to believe, since it is their bodies doing the work and they claim ownership over their bodies.

Many midwifery practices, and some obstetricians, will have women and their partners write out a birth plan, which is a list of things they would like to see happen during the birth of their child. This plan may include requests for the use of a birthing tub, a mirror for the mother to watch her child emerge from her body, and for the father to cut the umbilical cord. The reality is that many attending medical staff do not read the birth plan, let alone pay attention to the written wishes of the parents. If a birth is seen as a deviation of 'normal', then it is labelled a crisis and in need of medical intervention, and the plans that parents had put so much effort into writing are immediately disregarded by medical staff. This scenario results in a 'failed' birth plan for the parents. Several of the women interviewed had written birth plans on the recommendation of their primary caregivers. They believed that they would be an active player in directing the birth and that all they had envisioned in their plan would become reality. All of these women experienced a deep sense of failure and regret that their plans were not carried out and anger at their medical caregivers for not holding to that patient-centred model. It is interesting to note that birth plans were not a priority for these women for their subsequent births.

Contributions of this Research

This research study used a feminist approach to interviewing. The women were given the opportunity to speak freely, without interruption, judgment or restriction. They recounted their story in as much detail as they desired, which allowed a greater understanding of the many issues related to their experience of an unplanned caesarean section delivery. Providing this type of arena, where participants were engaged in more of a conversation rather than a formal interview, allowed the women an opportunity to consider their experiences.

All of the women reported that the interview process had been a positive experience. Some stated that speaking to someone on an individual basis, as opposed to a group setting, provided them with an opportunity they had not had before. They appreciated having someone listen to their story without interruption or advice as to how things could have been done differently.

As a researcher, I learned that the healing related to caesarean sections is an ongoing process. While all of the women thought they had recovered from the emotional trauma, they also stated that they will never forget the experience and the accompanying sense of regret.

The information generated by this study shows that women are in need of active support following an unplanned caesarean section. All of the women interviewed stated that they had learned about the possibility of caesarean sections for delivery during prenatal classes, but they did not think that it could happen to them, and so did not prepare for the possibility before the birth.

As was expected for this sample of women, each reported feeling strong negative emotions following the birth. All were surprised by their feelings and had a difficult time assimilating those feelings into their everyday lives, which were also filled with the challenges of new parenthood. The conflicting emotions that they felt from the birth led one woman to the brink of depression and others to seriously consider not having more children for fear of another traumatic delivery.

The results of this research study are congruent with results previous presented by other researchers. Women having undergone an unplanned caesarean delivery are at risk of emotional trauma. Although none of the women interviewed required medical intervention to deal with the emotional upset, previous research has shown that depression and even post-traumatic stress disorder are not uncommon following traumatic birth experiences (Ballard et al, 1995; Boyce et al, 1992; Creedy et al, 2000; McIntosh, 1993; Reynolds, 1997). These women sought out the support of like-minded women who had similar difficulties following their unplanned caesarean sections. While that support was valuable, all women stated that they would have benefited from professional support and the opportunity to speak about their feelings with someone on a one-to-one basis.

Implications and Recommendations for Social Work Practice

The women interviewed for this study did not prepare for an unplanned caesarean section. As noted earlier, women who arrange for a caesarean delivery have some advantage since their expectations are closer to their perceived reality. Planned caesarean

sections give women some control over decision making, provides an opportunity to process feelings prior to the delivery, and enables parents to attempt to come to terms with the loss of a 'normal' birth experience.

In an effort to help women manage negative feelings associated with an unplanned caesarean delivery, hospital social workers could offer support to women and their families during both the birth and the postpartum period. Respondents suggested a variety of ways that professionals could be of benefit. They stated that the emphasis could be on active listening, acceptance of the disappointment, reassurance of the common situation that they are in, and some anticipation of what they are going to go through in the near future.

Prenatally, social workers can organize or attend childbirth preparation classes to increase awareness of the range of emotions that can occur following birth. These need not be limited to the emotional responses that may be experienced following an unplanned caesarean delivery, but also any other traumatic childbirth experience. Even the most uneventful birth can have a long lasting impact on the emotional state of new mothers. Social workers could also use this opportunity to raise awareness of the high incidence of post-partum depression. Resources can be provided to women and their partners, and family members can be educated about the signs of emotional distress and the range of ways in which they could be helpfully responsive.

Discussions surrounding parents' expectations of the birth should be held. These explorations could be done during prenatal classes by the instructor or by a social worker. Parents should be informed of the fact that birth is not a predictable event and that their

preconceived expectations for the birth may not translate into reality. Parents should be advised of the possibility that the medical staff may not adhere to a birth plan, and be informed that a birth plan can serve as a guide only, not a doctrine.

There is the occasional situation in which an unplanned caesarean delivery is advised but the procedure is delayed for a number of hours. Social workers could be called in at this point to counsel the parents on any strong emotions they may be having about the decision. Nursing staff could be educated by social workers to provide at least some of this information to women and their families in the cases when the procedure will occur soon after the decision is made or when a social worker is unavailable.

Social workers could provide information and education to medical personnel about the emotional needs of birthing women, with particular emphasis on the unique needs of women who have undergone an unplanned caesarean delivery. Nurses and physicians can be made aware of the need for improved communication between medical staff and the mother and her family about the need for the emergency procedure. Medical staff should also be informed of the variety of emotions that can occur following a traumatic birth experience, and assist in devising plans to moderate any resulting emotional trauma.

Based on the results of this study, support groups can be fundamental to recovery. Social workers could facilitate support groups within the hospital and in the community for women who have been traumatized by their birth experience. By providing a safe environment in which women can discuss their emotions regarding an unplanned caesarean section, be it either a support group or one-on-one sessions, social workers can

assist the healing process. Educating support people and medical professionals is necessary and would certainly aid recovery. Liaising with other community support agencies and connecting women with them can help to ensure that women will get the support they need in the days and months following the birth of their child.

Limitations and Future Directions

It should be understood that the results of this study cannot be generalized for the larger population due to the small size of the sample. The participants interviewed for this study were also a unique group of women in that they were self-identified as having negative emotional responses to their unplanned caesarean sections and were motivated to seek support beyond their friends and families. These women had received a significant amount of information and education surrounding the medical management of birth and the sometimes premature use of caesarean sections following their own experiences of their unplanned caesarean sections. The women interviewed had given a great deal of thought to the events surrounding their unplanned caesarean deliveries and had discussed their experiences with a number of individuals on a regular basis. Their participation in a community support and awareness group facilitated their own recoveries through the opportunity to connect with others who had similar experiences, and by the opportunity to offer support and guidance to new members who had been traumatized by the events surrounding their own childbirth experiences. The advantage in interviewing this group of respondents is that they were articulate spokespersons for a group of women who should be getting attention from social workers in health settings.

Future research could use a random sample of women having undergone an unplanned caesarean delivery to allow for a broader perspective and to determine the prevalence of this response. A random sample would include women representing greater diversity, unlike this study where all of the women shared similar demographic characteristics.

It would appear that the loss of control experienced by the women in this study is a major factor in determining the negative responses they experienced. This hypothesis could be tested using a comparative analysis of women who have recently delivered their children by unplanned caesarean sections and women who have had a planned caesarean section.

Additionally, an unplanned caesarean section may affect how women plan for a subsequent delivery. As was noted by some of the women in this study, it was not until they began to consider having another child that their feelings of failure, guilt and disappointment come to the fore. Research focussing on how women's feelings about their unplanned caesarean section influence their planning for future deliveries is an area for further exploration.

If hospital support programs became available to women, studies to evaluate their effectiveness should be initiated to determine the number and population of women using the services. Assessments provided by the social workers and the medical professionals directly related to the programs would also offer important information as to the effectiveness and benefit of these initiatives.

CONCLUSIONS

Based on the literature reviewed for this study, women can have a variety of emotional responses to an unplanned caesarean section delivery. These emotions are often intense and are predominantly negative, ranging from feelings of guilt and disappointment, to anger directed at themselves and the medical staff who assisted them. This study sought to explore the emotional responses of women within the community who have identified themselves as facing emotional challenges as a result of their unplanned caesarean deliveries.

The women in this study partly attributed their negative emotions to the fact that they had not prepared for the possibility of a caesarean delivery. Although none stated that they had strong beliefs about how the birth would unfold, it was apparent from the intensity of the emotional reactions reported that their expectations of the birth were far from their actual experiences. While these women primarily blamed themselves for not being sufficiently prepared or informed, they also believed that the callousness and lack of concern demonstrated by the medical staff contributed to their resulting trauma.

Although all women in this study were supported during the birth by their partners and other family members, feelings of loneliness and isolation as a result of conflicting emotions were prevalent. Women in this study reported that they were able to receive support from a community organization of like-minded women and they all

claimed that they would have benefited in the immediate postpartum period from speaking to a trained professional about the disparity between the birth experience and their expectations for the delivery of a healthy baby. Previous research corroborates this finding, stating that allowing women to process their feelings surrounding a traumatic birth experience facilitates healing and recovery (Hillian, 2000; Marut, 1978).

Although the sample used in this study was small and the participants were limited in terms of representing a cross-sectional sample of the population, the findings generated from this study were consistent with the emotional responses of women to caesarean deliveries reported in the literature.

Clearly, there is a role for social workers in the birthing process, as supporters and educators to women and medical professionals. Women must be given the opportunity to discuss their feelings in a safe environment and medical staff must be educated about the variety of complex issues that may arise for women and their families surrounding an unplanned caesarean birth, and the fact that it can be a traumatic experience for the parents.

Further research is needed in order to adequately determine the unique needs of this population of birthing women. However, at this stage it is important to simply recognize that some women may experience strong emotional responses to an unplanned caesarean delivery that could require the support and guidance of both family and friends as well as professionals such as social workers.

REFERENCES

Affonso, D.D. & Stichler, J.F. (1980). Caesarean Birth: Women's Reactions. American Journal of Nursing. March: 468-470.

Ballard, C.G., Stanley, A.K., & Brockington, I.F. (1995). Post-Traumatic Stress Disorder (PTSD) after Childbirth. British Journal of Psychiatry. 166: 525-528.

Banack, C. (2002). Pushing Positions. Retrieved on March 14, 2004. http://www.ican-online.org/resources/white_papers/wp_pushing.htm

Biringer, A., Davies, B., Nimrod, C., Sternberg, C., and Youens, W. (2000). "Attaining and Maintaining Best Practices in the use of Caesarean Sections: An Analysis of four Ontario Hospitals". Report of the Caesarean Section Working Group of the Ontario Women's Health Council, June 2000.

Boyce, P.M & Todd, A.L. (1992). Increased Risk of Postnatal Depression after Emergency Caesarean Section. The Medical Journal of Australia. 157: 172-174.

Buckley, S. (1998). Epidurals – Real Risks for Mother and Baby. Retrieved on March 14, 2004. http://www.ican-online.org/resources/white_papers/wp_epidurals1.htm

Canadian Institute for Health Indicators (2004). Retrieved on April 29, 2004. http://secure.cihi.ca/cihiweb/dispPage.jsp?cw-page=media_21apr2004_e

Clement, S. (2001). Psychological aspects of caesarean section. Best Practice & Research Clinical Obstetrics & Gynecology. 15(1): 109-126.

Cohen, N.W. & Estner, L.J. (1983). Silent Knife: Caesarean Prevention and Vaginal Birth after Caesarean. South Hadley, MA: Bergin and Garvey Publishers.

Cox, B.E., Smith, E.C. (1982). The Mother's Self-Esteem After a Caesarean Delivery. Maternal Child Nursing. 7: 309-314.

Creedy, D.K., Shochet, I.M., Horsfall, J. (2000). Childbirth and the Development of Acute Trauma Symptoms: Incidence and Contributing Factors. Birth. 27(2): 104-111.

Culp, R.E. & Osofsky, H.J. (1989). Effects of Caesarean Delivery on Parental Depression, Marital Adjustment, and Mother-infant Interaction. Birth. 16(2): 53-57.

Davis-Floyd, R. (2001). The Technocratic, Humanistic, and Holistic Paradigms of Childbirth. International Journal of Gynecology and Obstetrics. 75(Supplement No.1): 5-23.

Deutchman, M. (2001). Caesarean Delivery and Hospitals: Size Matters. The Journal of Family Practice. 50(3): 224-225.

Dye, N. Schrom. (1986). The Medicalization of Birth. In Eakins, P.S. (Ed.), The American Way of Birth. (pp 21-46). Philadelphia: Temple University Press.

Flamm, B.L. (1990). Birth After Caesarean: The Medical Facts. New York, NY: Prentice Hall Press.

Gabert, H.A. & Bey, M. (1988). History and Development of Caesarean Operation. Obstetric and Gynecology Clinics of North America. 15(4): 591-605.

Goyert, G.L.; Bottoms, S.F.; Treadwell, M.C.; Nehra, P.C. (1989). The Physician Factor in Caesarean Birth Rates. The New England Journal of Medicine. 320(11): 706-709.

Grace, J.T. (1978). Good Grief: Coming to Terms with the Childbirth Experience. JOGNN. January/February: 18-22.

Green, J.M., Coupland, V.A. & Kitzinger, B.A. (1990). Expectations, Experiences, and Psychological Outcomes of Childbirth: A Prospective Study of 825 Women. Birth. 17(1): 15-24.

Guillemette, J. & Fraser, W.D. (1992). Differences between Obstetricians in Caesarean Section Rates and the Management of Labour. British Journal of Obstetrics and Gyneacology. 99: 105-108.

Hanmer, J. (1993). Women and Reproduction. In Richardson, D. & Robertson, V. (Eds.), Thinking Feminist: Key Concepts in Women's Studies. (pp 224-249). New York, NY: The Guilford Press.

Health Canada. (2000). The State of Perinatal Health in Canada.

Hillian, E. (2000). The aftermath of caesarean delivery. MIDIRS Midwifery Digest. 10(1): 70-72.

Hockey, J. (1993). Women and Health. In Richardson, D. & Robertson, V. (Eds.), Thinking Feminist: Key Concepts in Women's Studies. (pp 250-271). New York, NY: The Guilford Press.

Jannsen, P.A., Klein, M.C., & Soolsma, J.H. (2001). Differences in Institutional Caesarean Delivery Rates: The Role of Pain Management. The Journal of Family Practice. 50(3): 217-223.

Lawrence, C. Childbirth Policies: Evidence and Orthodoxy. Retrieved on January 16, 2004. http://www.carmenlawrence.com/says/papers/childbirth.htm

Lundy, M. & Mason, S. (1994). Women's Health Care Centers: Multiple Definitions. In Olson, M.M. (Ed), Women's Health and Social Work: Feminist Perspectives. (pp 109- 122). New York, NY: The Hawthorn Press, Inc.

Marut, J.S. (1978). The Special Needs of the Caesarean Mother. Maternal Child Nursing. July/August: 202-206.

McIntosh, J. (1993). Postpartum depression: women's help-seeking behaviour and perceptions of cause. Journal of Advanced Nursing. 18: 178-184.

Michie, H. & Cahn, N.R. (1996). Unnatural Births: Caesarean Sections in the Discourse of the "Natural Childbirth Movement". In Sargent, C.F. & Brettell, C. B. (Eds.), Gender and Health: An International Perspective. (pp 44-56). New Jersey: Prentice Hall, Inc.

Miovech, S.M., Knapp, H., Borucki, L., Roncoli, M., Arnold, L., & Brooten, D. (1994). Major Concerns of Women After Caesarean Delivery. JOGNN. 23(1): 53-59.

Mitford, J. (1992). The American Way of Birth. New York, NY: Penguin Books.

Neysmith, S.M. (1995). Feminist Methodologies: A Consideration of Principles and Practice for Research in Gerontology. Canadian Journal on Aging. 14 (Supplement No. 1): 87-96.

Oakley, A. (1983). Social Consequences of Obstetric Technology: The Importance of Measuring 'Soft' Outcomes. Birth. 10(2): 99-108.

Ontario Women's Health Council. (2002). Women's Health – An Excerpt of Hospital Report 2002: Acute Care. Retrieved on March 18, 2004. http://www.womenshealthcouncil.on.ca/scripts/index_.asp?action=31&P_ID=1741&N_ID=1&PT_ID=19&U_ID=0

Panel of the National Consensus Conference on Aspects of Caesarean Birth. (1986). Indications for caesarean sections: final statement of the Panel of the National Consensus Conference on Aspects of Caesarean Birth. Canadian Medical Association Journal. 134: 1348-1352.

Peterson, G. (1984). Birthing Normally: A Personal Growth Approach to Childbirth. Berkeley: Shadow and Light.

Reichert, J.A., Baron, M., & Fawcett, J. (1993). Changes in Attitudes Toward Caesarean Birth. JOGNN. 22(2): 159-167.

Reynolds, J.L. (1997). Post-traumatic stress disorder after childbirth: the phenomenon of traumatic birth. Canadian Medical Association Journal. 156(6): 831-835.

Rothman, B. K. (1982). In Labor: Women and Power in the Birthplace. New York, NY: W.W. Norton and Company.

Rothman, B. K. (1986). The Social Construction of Birth. In Eakins, P.S. (Ed.), The American Way of Birth. (pp 104-118). Philadelphia: Temple University Press.

Rothman, B.K. (1989). Recreating Motherhood: Ideology and Technology in a Patriarchal Society. New York, NY: W.W. Norton & Company.

Ryding, E.L. Wijma, K. & Wijma, B. (1999). Experiences of Emergency Caesarean Section: A Phenomenological Study of 53 Women. Birth. 25(4): 246-251.

Sandelowski, M. (1984). Expectations for Childbirth Versus Actual Experiences: The Gap Widens. Maternal Child Nursing. 9: 237-239.

Sandelowski, M. & Bustamante, R. 1986). Caesarean Birth Outside the Natural Childbirth Culture. Research in Nursing and Health. 9: 81-88.

Sawicki, J. (1999). Disciplining Mothers: Feminism and the New Reproductive Technologies. In Price, J. & Shildrick, M. (Eds.), Feminist Theory and the Body: A Reader. (pp 190-202). New York, NY: Routledge.

Schriefer, A. (2001). Shifting the Medical Gaze: Towards a Feminist Ethic of Childbirth. Retrieved on January 26, 2004. http://www.gwu.edu/-medusa/childbirth.html

Sewell, J. E. (1993). Caesarean – A Brief History. Washington, D.C.: The American College of Obstetricians and Gynecologists and the National Library.

Slade, P., MacPherson, S.A., Hume, A. & Maresh, M. (1993). Expectations, experiences and satisfaction with labour. British Journal of Clinical Psychology. 32: 469-483.

Society of Obstetricians and Gynecologists of Canada. (1995). Clinical Practice Guidelines: Dystocia.

Society of Obstetricians and Gynecologists of Canada. (2002). Clinical Practice Guidelines: Fetal Health Surveillance.

Statistics Canada. (2000). Health Indicators. Retrieved on February 22, 2004. http://www.statcan.ca/english/freepub/82-221-XIE/tables/htmltables/c3t02.htm

Statistics Canada. (2002).

Summey, P.S. (1986). Caesarean Birth. In Eakins, P.S. (Ed.), The American Way of Birth. (pp 175-195). Philadelphia: Temple University Press.

Treichler, P. (1990). Feminism, Medicine, and the Meaning of Childbirth. In Jacobus, M., Keller, E.F. & Shuttleworth, S. (Eds.), Body/Politics: Women and the Discourses of Science. (pp 113-138). New York, NY: Routledge.

APPENDICES

Appendix A: Interview Guide

Demographic questions will include:

- What is your age?
- What was your age at the time of your first unanticipated caesarean section?
- What is your self-identified cultural and ethnic background?
- Was this your first birth?
- How many prior births had you had?
- How many caesarean deliveries have you had?
- What is your education level?

Broad areas for questions and probes will include:

- What is the story of your unplanned caesarean section?
- What were your expectations and/or plans surrounding that birth?
- Where did the ideas that shaped your expectations come from?
- Whose opinion did you value when you were planning your birth?
- Were your partner's expectations of the birth congruent with your own?
- What feelings did you experience in regard to your caesarean section during and after it occurred? What are your feelings now?
- Have there been changes in your feelings over time? Is there anything that stimulated these changes?
- What has been most helpful to your ability to cope? What helped you to bridge the gap between your expectations and your experience?
- What has hindered your ability to cope?
- Are there still things that bother you about your experience?
- Have you recovered from your experience? How do you know?

Appendix B: Letter of Information

The purpose of this research is to explore women's responses to unplanned caesarean sections. Women will often have various expectations for their labour and delivery that may not match their experience. The study seeks to understand how women's expectations of their birth experience shaped their understanding of that experience and what has helped them to cope with their unplanned caesarean delivery.

Literature has shown that when women plan for 'natural childbirth' and have an unplanned caesarean section, they are not only faced with recovering from surgery and coping with motherhood, but also with sorting out a variety of thoughts and feelings which they may not have anticipated and for which they are not have prepared.

The results of this research, which are anonymous, may be published in appropriate journals and will be discussed with graduate faculty in the School of Social Work, McMaster University.

Your participation in this research will be kept confidential. Every care will be taken to respect your privacy and no identifying information will be included on any reports generated from this study. All data you provide will be kept in a locked cabinet in my home office. You will maintain the right to withdraw your participations in their study at any point in the process. Should you chose to withdraw, all data, including audiotapes and transcriptions, will be returned to you.

In participating in this study, you will be asked to meet with the interviewer for one session that will last between one and two hours. You may choose to meet either at the university or in your home. During the interview you will be asked to provide a personal narrative or story of your experiences of your unplanned caesarean section. This session will be tape-recorded.

You will receive a written summary report of the findings from this research. This project has been reviewed and received clearance by the McMaster Research Ethics Board. Should you have any questions about your participation in this study you may contact this Board at 905-525-9140 x 24765.

Lisa Harripersad, B.A., B.S.W.
M.S.W. Student

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Professor & Thesis Supervisor
School of Social Work

Appendix C: Consent Form

I agree to take part in this study examining women's' responses to their unplanned caesarean section. I have been fully informed about this study and I understand its purpose.

I understand that Lisa Harripersad is the principle investigator of their study, and that Dr. Susan Watt, a faculty member of the McMaster School of Social Work, is supervising her actions in this capacity.

I am willing to take part in one interview that will last between one to two hours and am agreeable to having this interview audio taped and transcribed. I understand that I may decline to answer any particular question. I also understand that I may access any information that I have provided at this time.

I understand that I can chose to withdraw from this study at any time and that, if I do, any data that I provided, including audiotapes and transcriptions will be returned to me.

I understand that my confidentiality is assured, and that any identifying information will be removed from the data I supply.

I understand that anonymous results of this study may be published in academic journals and presented at appropriate professional conferences.

Signed:_____

Dated:_____