

Faculty of Health Sciences, School of Nursing and Midwifery

**Becoming Redundant: Women's Experience of Unwanted Scheduled
Caesarean Section - A Grounded Theory Study**

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of
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Statement of Originality

To the best of my knowledge and belief this thesis contains no material previously published by any other person except where due acknowledgment has been made.

This thesis contains no material which has been accepted for the award of any other degree or diploma in any university.

Signature _____

Date _____

Acknowledgments

There is no doubt that the completion of this thesis has only been possible because of the support of a huge number of people to whom an enormous debt of gratitude is due.

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This thesis is dedicated to Adele James

Abstract

Currently, one third of Australian childbearing women per annum have a caesarean section. Evidence strongly indicates, however, that most women enter into pregnancy expecting and wanting to give birth naturally. While a body of research exists that accounts for some aspects of how women experience caesarean section, the phenomenon has not previously been described in depth. The purpose of this study was to uncover and theorise how women processed and experienced a first caesarean recommended in pregnancy for a health reason.

This Western Australian investigation was conducted using the Glaserian version of Grounded Theory methodology. Twenty-eight pregnant women who had been anticipating giving birth naturally, but were advised during pregnancy that they would need to give birth by caesarean section, agreed to participate in the study. Five sets of data were collected. The first comprised semi-structured in depth interviews with the 28 women both before and after the birth of their baby. Non-participant observations of women's behaviours and interactions whilst they were in the operating theatre, including situation maps, written notes and pencil sketches, formed the second data set. The third and fourth sets of data consisted of semi-structured interviews held with participating women's partners and with maternity health care professionals. Field notes formed the final set.

The Grounded Theory that emerged was labelled **Becoming Redundant**. The theory comprises the core problem that anticipating and experiencing a scheduled caesarean section posed for women, namely **Being Made Redundant**, and the psychosocial process they undertook to manage it, labelled **Regrouping**. In total, eight major categories were identified. The four categories that contributed to the core problem were labelled **Being robbed**, **Becoming a 'persona non grata'**, **Off everyone's radar** and **Left wanting**. The categories in the regrouping process were labelled **Trying to make it feel real**, **Travelling a new path blindly**, **Striving to be included whilst trying to behave** and **Treading water**. In addition, four factors emerged from the data that moderated, or limited, women's regrouping endeavours. These were titled *Expecting birth would be natural*, *Hurling towards 'D-day'*, *The green drape* and *Caesarean section is hospital not women's business*.

For 25 of the 28 women, needing and having a caesarean section was frightening, disempowering, distressing and in complete contrast with how they had expected and wanted their baby's birth to be. The childbirth expectations of these 25 women were shattered as the hospital effectively took over their baby's birth, and they were left with feelings of loss, grief and, in some cases, symptoms of emotional trauma. In response, women set about trying to accommodate the personal losses they incurred, and to transition to their 'new reality'. The effect of the moderating factors, however, was to thwart women's adaptation efforts. Consequently, when they were interviewed between 10 and 14 weeks after their caesarean section, these 25 women reported feeling cognitively and emotionally 'stuck' in their childbearing experience. They also described spending considerable energy and attention on trying to work out what had happened to them rather than focusing on their new baby.

The remaining three women either experienced or responded to their scheduled caesarean section differently to the other 25; this was because of the absence of one or more of the moderating factors. Ultimately, however, only one of the women was left feeling positive, emotionally on a 'high' and free of regret after her baby's birth.

This Western Australian research highlights significant new findings about women who require a caesarean section for a health reason. The work makes an important and original contribution not only to the maternity literature, but to the body of knowledge concerning grief, traumatic stress and dissociation, and change transition. The theory of **Becoming Redundant** provides maternity care professionals, academics and consumers with previously unknown information about how women might experience, manage and be affected by unforeseen and unwelcome change during the childbearing episode, and has direct and important implications for the care of childbearing women. The disappointment, grief and/or traumatic stress that is likely to arise for a woman when her childbearing expectations can no longer be fulfilled must be anticipated, recognised, acknowledged and forestalled where possible. For women to integrate and move on from their childbirth experience and become fully engaged in motherhood, those who have had to 'change track' must be afforded the time, space and support to explore the meaning of the change, to fully mourn what they lose because of it, and to recapture their losses to the greatest extent possible.

Table of Contents

Statement of originality	2
Acknowledgements	3
Abstract	4
Table of Contents	6
Table of Figures	12
Chapter 1	14
Setting the Scene	
Introduction	14
Background and justification of the study	19
Overview of the thesis	21
Summary	23
Chapter 2	24
The Caesarean Section through History	
Introduction	24
Etymology	25
The 8 th century BC to the 1990s	26
The new Millennium	32
Implications of caesarean section	35
Maternal morbidity and mortality	36
Consequences for neonates	36
Emotional wellbeing	37
Preliminary literature review	39
Summary	42

Chapter 3	43
Taking a Glaserian Approach to ‘Doing’ Grounded Theory	
Introduction	43
Positivism vs. naturalistic interpretivism	43
Grounded Theory methodology	45
Background and origins	46
Objectivist vs. Constructivist Grounded Theory	48
Selecting Glaserian Grounded Theory	50
Confirming the need for a qualitative approach	50
Identifying with the Glaserian perspective	51
The methodological processes of Grounded Theory	52
Sampling, recruitment and data collection	53
Sampling	54
<i>Inclusion and exclusion criteria</i>	54
<i>Recruitment of participant women</i>	54
<i>Recruitment of health care professionals</i>	55
<i>Recruitment of women’s partners</i>	56
Profile of participants	56
Data collection	58
Antenatal interviews with women	58
<i>Non-participant observation of clinical environments</i>	59
<i>Postnatal interviews with women</i>	63
<i>Interviews with maternity healthcare professionals</i>	63
<i>Interviews with women’s partners</i>	64
<i>Field notes</i>	64
‘Bracketing’ prior to data collection	65
Data handling and management	66

Data analysis and theory generation	67
Analysis of women’s interview data	68
<i>Stage one coding</i>	68
<i>Stage two coding</i>	73
<i>Stage three coding</i>	73
<i>Stage four coding</i>	76
Analysis of remaining data	76
Trustworthiness	77
Ethical considerations	79
Summary	81
Chapter 4	83
‘Needing and Awaiting’ Caesarean Section	
Introduction	83
Overview of the findings	83
Feeling robbed	86
Becoming a ‘persona non grata’	90
Trying to make it feel real	97
Making sure a caesarean’s really necessary	97
Broadcasting the news	99
Searching for information	102
Travelling a new path blindly	104
Trying to make the best of it	104
Rehearsing	106
Summary	108
Chapter 5	110
Birth and Beyond	

Introduction	110
Off everyone's radar	110
Just another case on an operating list	111
Unable to be my baby's mum	114
Striving to be included whilst trying to behave	119
Left wanting	123
Treading water	125
Summary	127
Chapter 6	129
Moderating Factors and Negative cases	
Introduction	129
Expecting and wanting birth to be natural	128
Hurtling towards 'd-day'	131
The green drape	132
Caesarean section is hospital not women's business	138
Ginny and Pauline	144
Michelle	149
Summary	154
Chapter 7	155
Disintegrated Expectations and a New Reality	
Introduction	155
Part1: The disintegration of childbirth expectations	156
The aetiology of perceived loss	157
<i>Loss of the opportunity to give birth naturally</i>	158
<i>Loss of role and responsibility for birth</i>	158
<i>Loss of joy, confidence and security</i>	159

<i>Loss of others' regard and esteem</i>	165
<i>Loss of the opportunity to complete certain rites of childbearing</i>	167
<i>Loss of connection to the baby</i>	169
The contribution of institutional paternalism to birthing Redundancy	171
Reacting to psychosocial loss	173
<i>Grief</i>	173
<i>Traumatic stress</i>	175
Health implications of loss, grief and traumatic stress	176
Part 2: Trying to Accommodate a New Reality	180
Change, loss and psychosocial transitioning	181
Being unable to find a way in the dark	183
Failing to stay in control in the operating room	188
Mothering in limbo	190
Summary	193
Chapter 8	195
Future Directions and Final Thoughts	
Introduction	195
Overview of the study	194
Review of the theory	196
Limitations	201
Recommendations	202
Maternity care philosophy, design and practice	203
Philosophy of care	203
Care design and delivery	204
Education of maternity care professionals	206

Women’s primal need for centrality in and command over their baby’s birth	206
Issues of power and control in maternity settings	207
Breaking bad news, the grief response and the facilitation of change	207
Future research	208
Concluding remarks	210
Epilogue	212
The Implementation of Clinical Initiatives to Improve Women’s Experience of Scheduled Caesarean Section	
Appendices	217
Appendix 1. Information sheets for women, partners and staff	218
Appendix 2. Consent forms for women, partners and staff	226
Appendix 3. Profile of participant women	229
Appendix 4. Semi-structured guides for early interviews with women, partners and staff.	231
Appendix 5. Line diagram of operating theatre for non-participant observational data collection	234
Appendix 6. MR 290.1: Scheduled Caesarean Section Birth Plan	235
References	236

Table of Figures

		Page
1.	Woodcut depicting a live infant, commonly believed to be Julius Caesar, being surgically removed from a woman	27
2.	First known illustration of a caesarean section by Al-Biruni in the 2 nd century C.E.	28
3.	Caesarean section performed by a female.	29
4.	The female pelvic anatomy from Vesalius's <i>De Corporis Humani Fabrica</i> , first published in 1543	30
5.	Record made during non-participant observation of caesarean section in the operating theatre	61
6.	Pencil sketch made during non-participant observation of caesarean section in the operating theatre.	62
7.	Pre-admission clinic field note of 17 th April 2007	65
8.	Example of first level coding	69
9.	Memo – example 1	70
10.	Memo – example 2	71
11.	Memo – example 3	71
12.	Example of categorical ‘one-upping’	75
13.	Final order of theoretical concepts: ‘Becoming Redundant’	76
14.	Development of major category of core problem – ‘off the radar’	80
15.	Excerpt from transcript of interview with Tina	88
16.	Field note: researcher reflections on Tina’s ‘fear of dying’ disclosure	89
17.	Field note: researcher reflection on focus of clinic appointments	93
18.	Field note: researcher reflection on behavioural dissonance (Julia)	105
19.	Excerpt from non-participant observations - Cherry’s journey through the hospital on the day of her caesarean section	112
20.	Observational note: Anne’s caesarean section	114
21.	Observational sketch of Donna’s baby being received by neonatologist	116

22.	Observational sketch: New mother Rose left alone in the operating theatre	118
23.	Observational sketch: Jan, frightened, trying to make eye contact with partner	121
24.	Observational sketch: Rose behind by the sterile green drape	133
25.	Participant (Tina's) 'cut in half' sketch	134
26.	Observational notes: two climatic zones of the operating theatre	136
27.	Observational sketch: number of staff 'beyond the green drape'	135
28.	Excerpt from transcript of interview with Obstetrician Helen	140
29.	Field note: reflection on pre-admission clinic midwife talk	142
30.	Clinical Guideline No. 7.7 'Caesarean Section: Post-Operative Care'	143
31.	Observational sketch: Michelle in the operating theatre	153

Chapter 1

Setting the Scene

Really when I think about it now, I look back and I can see... all the little things, different situations that made me feel so 'blah'... you know, why I was so "Huh?" You know, so "what?" about the whole thing. You're just a tiny blip in a bigger system. You don't come into it. My mistake was thinking I...my baby's birth was as big a deal...or, journey, celebration, whatever... to everyone else as it was to me but it was just...well it was just "in, out, next".

(Cherry, 13 weeks postnatal)

Introduction

Childbirth is now known to be much more than a biological process; it is considered a rite of womanhood, a seminal life event for women that is so multi-dimensional it is difficult to describe (Callister 1995; Waldenström, Borg et al. 1996; Nelson 2003). It is now irrefutably established that a woman's experience of childbearing is central to her own well-being and sense of self, which in turn has seminal importance for her family's future health (Brown and Lumley 1998; Saurel-Cubizolles, Romito et al. 2000; Parratt 2002). A positive birth experience is likely to imbue women with a sense of deeply gratifying accomplishment. An unhappy experience, however, is known to have negative consequences not only for the biopsychosocial health and well-being of the woman but also for her children and her family life (Mercer and Marut 1981; Sinclair and Murray 1998; Hay, Pawlby et al. 2001; Goodman, Mackey et al. 2004; Waldenström, Hildingsson et al. 2004).

A number of factors are now recognised to be important for how women evaluate their experience of childbirth. These include the attitudes and behaviours of caregivers, length of labour, level of distress, the occurrence and extent of complications, the presence of a family member or friend, and involvement in decision-making (Howell-White 1999; Hodnett 2002; Domingues, Santos et al. 2004; Goodman, Mackey et al. 2004; Harriott, Williams et al. 2005; Lundgren 2005; Adewuya, Ologun et al. 2006; Maggioni, Margola et al. 2006). The fundamental

driver of women's childbirth satisfaction, though, seems to be the extent to which their experience met their original and often long-held expectations for the event (Soet, Brack et al. 2003).

Internationally, including in Australia, women's childbirth expectations have been found to include being in control during birth, being supported by their partner, being active in decision-making, being supported by midwives, that labour and birth would be long, difficult and painful, and that it would be either satisfying or unaffirming (Gibbins and Thomson 2001; Ip, Chien et al. 2003; Kao, Gau et al. 2004; Oweis and Abushaikha 2004; Fenwick, Hauck et al. 2005). One predominant cross-cultural assumption has now been firmly established, however: it seems that globally, the majority of women expect and/or want to give birth naturally (Gamble and Creedy 2001; de Oliveira, Riesco et al. 2002; Ip, Chien et al. 2003; Kao, Gau et al. 2004; Oweis and Abushaikha 2004; Fenwick, Hauck et al. 2005; Fenwick, Gamble et al. 2006). Despite this, one-fifth of childbearing women across the developed world (Betran, Merialdi et al. 2007), and approximately one-third in Australia (Laws and Hilder 2008), now have a caesarean section.

A caesarean section is a surgical procedure wherein a baby is retrieved from its mother's uterus through an incision made in the woman's abdomen. Traditionally, the procedure has been broadly classified as either 'elective', 'non-elective' or 'emergency'. More recently, however, a different categorisation system has been developed that more specifically reflects the urgency of the situation (National Confidential Enquiry into Perioperative Deaths 1995). The following excerpt from page 25 of the UK's National Institute of Clinical Excellence Clinical Guideline for caesarean section (National Collaborating Centre for Women's and Children's Health 2004) identifies and explains the new categories;

Grade 1 (immediate threat to the life of the woman or fetus) includes CS for acute severe bradycardia, cord prolapse, uterine rupture, fetal blood sampling pH less than 7.2. Grade 2 (maternal or fetal compromise which was not immediately life-threatening), there is 'urgency' to deliver the baby in order to prevent further deterioration of either the mother or baby's condition (e.g. antepartum haemorrhage, 'failure to progress' in labour with maternal or fetal compromise). Grade 3 (no maternal or fetal compromise but needs early delivery) includes CS carried out where there is no maternal or fetal compromise but early delivery is necessary (e.g. a woman booked for elective CS who is admitted with pre-labour SROM or 'failure to progress' with no maternal or fetal compromise).

Grade 4 (delivery timed to suit woman or staff) includes all CS carried out 'electively' at a planned time to suit the mother and clinicians.

In practice and in the literature, however, the binary and the four-category systems are still referred to interchangeably; a 'category 1' caesarean section is commonly also referred to as an 'emergency', categories 2 and 3 as 'non-elective', and 'category 4' as 'elective'. In addition, category 4 caesarean section is, colloquially, further sub-categorised as either 'medically necessary' or 'maternal preference'. A 'maternal preference' caesarean section is one that women have either requested or agreed to in the absence of any physiological indication, however most data systems do not capture this.

This thesis presents an in-depth study of how needing and having a 'category 4' (elective) caesarean section affected 28 Australian women's experiences of pregnancy, childbearing and early mothering. The primary aim of the study was to discover how women who had been expecting to give birth naturally anticipated, experienced and dealt with a caesarean section that was unexpectedly scheduled during pregnancy for a health reason. The intended outcome was to produce a substantive theory based on a conceptual understanding of the common problems raised by these women, who had no option but to give birth in this way.

The research presented in this thesis was conducted using the Glaserian (classic, or original) approach to Grounded Theory. Originated by sociologists Barney Glaser and Anselm Strauss in the mid-1960s (Glaser and Strauss 1967), the methodology was then developed further by Glaser (1978; 1992; 1998; 2001; Glaser and Holton 2004) and separately by Strauss (1990; Strauss and Corbin 1994; Strauss and Corbin 1998). Others have also published their own variants of the methodology (see for example Charmaz 2006). Grounded Theory was chosen as the methodology for this research because it promised a means by which to discover 'all there was to know' about this phenomenon. No other theory that comprehensively explained the personal experience of needing, anticipating and undergoing an elective caesarean section could be located.

In keeping with the Grounded Theory mandate to refrain from being too specific at the outset, the primary aim of the current study was originally framed as, *'How do women experience and process anticipating and giving birth by a medically*

necessary elective caesarean section?' The phrasing of the primary aim changed over time, however. When I began to approach and talk with women about the study, it became apparent within the first few antenatal interviews that the term 'elective' was offensive. They felt it was a word which implied they had some participation in and choice about the decision. They resented this implication, and rather vociferously wished it to be recognised that they were not complicit with the decision.

The word 'planned' was then proposed as an alternative, however women considered this to convey that they were part of the decision when they perceived they were not. The word 'scheduled' was finally agreed on as most succinctly describing women's sense of having had no part to play in the decision, but that it was made for them. For these first few women and for those that were asked subsequently, the word 'scheduled' aptly conveyed that caesarean section was happening to them without their desire, pursuit or involvement.

Interestingly, the women were not the only group who took issue with the wording of the primary study aim. A number of doctors at various levels of seniority independently challenged the use of the term 'medically necessary', as they felt it unfairly laid the blame for caesarean section with them. Again, a consultative process of searching for an agreeable alternative was followed, and the phrase 'medically necessary' was substituted by 'for a health reason'. The primary aim of the current study was then revised again following the first four interviews with doctors to its final form, *'How do women experience and process anticipating and giving birth by a caesarean section scheduled during pregnancy for a health reason?'* My secondary aim was to locate this research within existing knowledge.

Four specific research questions were then identified. These included:

- how do women **experience** the recommendation and subsequent decision to schedule a caesarean section, and the procedure itself?
- how do women **process** needing and having a necessary scheduled caesarean section?
- how do women reflect upon their antenatal and birth experiences?
- what factors, if any, facilitate the way in which women experience and

process needing, having and moving on from a necessary scheduled caesarean section?

The research was conducted between December 2006 and March 2008 at an Australian tertiary maternity unit. Twenty eight women were recruited, all of whom participated in two unstructured interviews that were digitally-recorded and transcribed verbatim. The first interview was conducted in the week prior to their caesarean section, and the second at between 10 and 14 weeks post-operative (postnatal). Each interview began with women being asked to describe how they were feeling about their scheduled caesarean section. As each interview progressed, women were asked to elaborate on, for example, their thoughts and feelings about being in need of or having had a scheduled caesarean section, how they perceived they were regarded and treated by others, how the decision had affected them, and how they had dealt or were dealing with various aspects of their experience.

Juxtaposed with the women's interview information are views on scheduled caesarean section held by 22 Australian maternity health care professionals working within the study setting at the time of data collection. These interviews were also unstructured, however key questions such as "how do you think women feel about having to have a caesarean section booked?" and "what do you enjoy or not enjoy about working with women having a scheduled caesarean section?" were asked of all. Additional unstructured interviews were conducted with 21 women's partners, to ascertain how they felt about their baby being born by scheduled caesarean section, how they thought their partner felt about it, and their experience of anticipating and being present during the procedure. Many of the women who were interviewed very generously agreed to have their behaviours and interactions observed and recorded whilst they were in the operating theatre and in other clinical settings. Field notes of informal interviews with nurses, doctors, midwives and women were also recorded and taken into account during data analysis. This use of multiple forms of data added rigour and validation to the study's findings. The study methodology and methods are detailed in Chapter Three.

My methodological remit was to gain *entrée* to the substantive setting, to collect data that would reveal what was happening for these women (Glaser and Strauss 1967), to systematically reduce the data using classic Grounded Theory techniques, and to

conceptualise the reduced data in order to generate a theory. By fulfilling this remit, I was able to meet the aim and objectives of the study, and discover both the core problem women faced when anticipating and experiencing a scheduled caesarean section and the basic social psychological process they employed to manage this experience (Glaser 1998).

Background and justification of the study

My interest in the subject of this research, women's experience of 'necessary' scheduled caesarean section, arose from a previous mixed methodology study I was involved in that investigated the incidence and levels of women's childbirth fear (Bayes, Fenwick et al. 2008; Fenwick, Gamble et al. 2009). In the interviews with pregnant women during the data collection period for this prior study, those booked to have a scheduled caesarean section for a health reason talked very differently about having a baby than other women did; they spoke about feeling aggrieved by the decision for the procedure even though they knew there was no other birth option for them. Some women appeared hurt, angry and upset about the need for a caesarean section, some were incredulous, and quite a few stated feeling as if they were now regarded as an abdomen, or an incubator. This, they said, was very different to how it had been when they had been anticipating having a natural birth. What was also apparent from many anecdotal interviews with women who were booked for a caesarean section was that they had a need to voice and explore their feelings about having to have a caesarean section, and this need appeared to have gone unrecognised by the health professionals they had encountered thus far. A subsequent cursory search of the literature demonstrated very limited work on this subject.

I am a midwife with extensive experience of caring for many women scheduled for and having scheduled caesarean sections, and I try to practise woman-centred and intuitive care. Still, the possibility that women who had no option but to have a scheduled caesarean section harboured any other feelings than complete acceptance was a revelation to me. It was also news to a number of midwifery, medical and nursing colleagues I mentioned it to. It seemed that maternity professionals have, on the whole, been completely unaware of how it really was for these women, and had been doing them a disservice in their care as a result. It became apparent to me that,

to care for these women appropriately, maternity professionals needed to know about how they experienced childbearing.

My personal and professional background has also influenced the inception and conduct of this research. I have not had a caesarean section, but I have had personal experience of both a pregnancy and a birth that were not straightforward and that each involved having several decisions taken out of my hands. I have also heard many joyful and not-so-wonderful childbearing stories of friends, acquaintances and family members over the last 35 years or so. I am not religious, but I have had a number of experiences that have suggested there are perhaps unseen forces at work in our lives. I also have a strong empathy with Buddhism and try to live in accordance with its principles of 'right intention', 'right speech', 'right action', 'right livelihood', 'right effort', 'right mindfulness' and 'right concentration'. I have had a very diverse occupational life that has involved working as a community artist and craftswoman, as a caseworker with the long-term unemployed, with women and children in domestic violence shelter accommodation, as a nurse in a number of environments and, as already mentioned, as a midwife in a variety of settings.

In 2005, I undertook a Master of Midwifery, during which I explored the nature of power in maternity care relationships. Following completion of this program, the opportunity arose to move into midwifery research project management for 12 months. It was during this time that my interest in qualitative research grew. The practise of qualitative research within a midwifery context, to me, epitomises many of the Buddhist values, particularly that of 'right livelihood'. I believe the endeavour to be honest, peaceful, emancipatory and feminist activism, in that it authenticates and honours women's 'real' childbirth and early mothering values, capabilities and experiences, and reveals them to others who might use the information to effect positive change for women. My abiding personal and professional motivator is that all women and babies deserve to have the best physical, psychological, emotional and social experience of birth that they can, regardless of the circumstances. It is from this foundation of influences that the research reported in this thesis was conceptualised, designed and carried out.

Of the Australian women who have a caesarean section each year, just under one-half are consistently reported to undergo a non-elective or emergency procedure during

labour (Laws, Grayson et al. 2006; Laws and Sullivan 2009). In these circumstances, the experience has been comprehensively documented as unsatisfying and unfulfilling (Porter, Van Teijlingen et al. 2007; Wiklund, Edman et al. 2008; Goldbort 2009). Non-elective caesarean section has been associated with diminution in maternal mood and self-esteem, a sense of having lost control, and feelings of detachment, indifference, helplessness and disappointment (Mutryn 1993; Fisher, Astbury et al. 1997). The incidence and degree of psychological-emotional morbidities such as post-natal depression and post-traumatic stress is also known to be higher in women who have experienced a non-elective or emergency caesarean section (Wijma, Söderquist et al. 1997; Ryding, Wijma et al. 1998; Wijma, Alehagen et al. 2002; Soet, Brack et al. 2003; Waldenström, Hildingsson et al. 2004).

Although there now exists a fairly comprehensive body of work reporting women's experience and perceptions of non-elective caesarean section, this is not the case for elective (scheduled) caesarean section. Given the exponential rise in the rate of caesarean sections performed before the commencement of labour in Australia and across the world, there is a pressing need to discover how having a baby in this way affects women.

Overview of the thesis

This thesis presents my journey through a research study to find out how a group of women who had been anticipating a natural birth dealt with suddenly and unexpectedly becoming unable to have one, and with needing a caesarean section. In this Chapter, the first of eight, the reader has been introduced to the rationale for an investigation into this phenomenon, and an overview of the study design and conduct has been provided. The influence of my personal and professional background on the research and on the thesis has also been acknowledged.

Chapter 2 is an acknowledgment of the fact that cultural beliefs about caesarean section, motives for performing it and confidence in it have changed radically over time. The procedure was originally carried out only in the very rarest of situations whereas now, it is one of the most commonly performed operations. Advances in our understanding of the human condition have meant that we are now more cognisant than ever of the health and safety implications of the procedure, particularly for otherwise-well mothers and babies. Gaps in our knowledge still remain, however.

Chapter 2 provides an extensive history of caesarean section, and comprehensive coverage of what is known of the effects and sequelae of the procedure for women, their infants, the wider family and ultimately, society. At the end of Chapter 2, a gap in the evidence-base that could be filled by a study of women's experience of a caesarean section scheduled unexpectedly during pregnancy for a health reason is clearly identified.

Chapter 3 is concerned with the design and conduct of this research. An explanation of the different research paradigms, and then of the philosophical and practical antecedents, tenets and development of Grounded Theory methodology are first provided. The information about Grounded Theory includes a debate over whether, although naturalistic influences are evident in it in terms of its adoption of Symbolic Interactionist principles, the methodology can truly be considered to be 'qualitative' given that it was founded primarily in the social phenomena quantification work of mathematician Paul Lazarsfeld. The use of Grounded Theory methodology for this investigation is justified, and the specific research design and methods utilised in the study are then detailed.

Collection, analysis and grouping of the data, although challenging, proved relatively straightforward, as did the discovery of the core problem, the basic social psychological process and the factors that moderated women's experience. Extreme difficulty arose, though, when I was trying to decide how to present the findings. Reporting the problem and the process separately would not have represented women's experience accurately. This is because in reality, the full extent of the problem women faced was not apparent from the outset; it only became clear over time. In light of this, women could only respond to their **redundancy** to the extent they were aware of it and as it revealed itself to them. It was decided that the most logical way to convey the parallel unfolding of the problem and the process was to report them temporally as they occurred.

Chapters 4, 5 and 6 of this thesis contain the findings of the research, and are richly illustrated with exemplary quotes from interviews, field note excerpts, and pencil sketches made in the operating theatre and other clinical environments, all of which serve to personalise the women's experiences for the reader. Chapter 4 opens with an overview of the findings, wherein the reader is introduced to the core problem of

Being Made Redundant and the basic social psychological process of **Regrouping**. Four moderating factors are also identified. The categories of the problem and the process that relate to the period between women being told of the need for a caesarean section and the end of their pregnancy are then presented in depth. The remainder of the categories concern the day of women's caesarean section and beyond, and are described in Chapter 5. Four factors were found to moderate women's childbearing experience, and to limit their capacity to process the problem engendered by needing and having a caesarean section. These factors are presented in Chapter 6, along with the stories of three of the women whose experiences were somewhat different to the others'.

The nature and meaning of the research findings are discussed in Chapter 7. The reader is first provided with a summary of the study, and the original aims of the work are reviewed. The findings of the investigation are compared to and considered against extant scientific literature and theory; in some cases, it was necessary to contextualise the findings within literature from disciplines other than midwifery and obstetrics.

In the eighth Chapter, the implications of the findings from this study for clinical practice, for education, for service design and delivery and for research are proposed. Recommendations are also made for each of these domains before the thesis is concluded. An Epilogue to the thesis provides an account of how, throughout the data collection and analysis period, the presence of the study in different clinical areas within the substantive setting altered clinical practice.

Summary

This first Chapter has apprised the reader of the background, rationale and influences on a research study investigating how women experience and process a caesarean section scheduled in pregnancy for health reasons. The conduct of the study has been outlined, and I have made mention of the difficulties I encountered in relation to reporting the findings. An outline of the remainder of the thesis has also been provided.

Chapter 2

The Caesarean Section through History

How did a magnificent rescue operation become such a common way of giving birth? And how safe is it really?

Michel Odent (2004)

Introduction

The purpose of this review of the extant literature is to provide clear justification for a new research study on this subject. Traditionally, Grounded Theory researchers have been warned away from the literature prior to collecting and analysing their data in case it leads to prejudice or leads to premature closure of ideas (Stern 1980). Academic convention, however, in accordance with the Australian National Health and Medical Research Council (NHMRC), requires that sound rationale for the conduct of research is demonstrated. According to the NHMRC (National Health & Medical Research Council 2007, p.12), a proposed research study must be “justifiable by its potential benefit” and “based on a thorough study of the current literature”. On this basis, search and review of the literature around the topic was performed. Work that was retrieved reporting women’s emotional experience of certain aspects of scheduled caesarean section, however, was set aside for use during discussion of the study findings.

The way in which caesarean section has been experienced by women throughout history has depended upon the underlying societal motives for its use. Caesarean section was once extreme and rare, driven by societal and religious edicts, and performed only to separate dead or dying women from the baby for separate burial. Rationale for the procedure has, however, broadened immensely over time, and has meant an unprecedented rise in its use. When last estimated, worldwide caesarean section rates varied between 12-70% (Laws and Sullivan 2005; Stanton and Holtz 2006). Nowhere in the developed world has the rate been reported as decreasing.

Despite established and mounting evidence to the contrary, there remains at this time a perception that caesarean section poses no risks to women and babies. The procedure has come to be regarded by many as safe, dependable and worry-free (Husslein 2001). Consequently, the perception of what is normal in childbirth has narrowed, the threshold for intervention has lowered, and a steady increase in global caesarean section rates has occurred. Papers reporting morbidity related to caesarean section have, however, begun to appear with increasing frequency in the literature. The discourse around caesarean section is now informed by a growing body of work on the undesirable physiological, emotional and psychological impact of caesarean section on mothers, babies and the family. Furthermore, the increase in the number of procedures performed has not been associated with a concomitant improvement in maternal and/or newborn well-being. In fact it has been identified that caesarean section in all but the most compelling situations confer increased risks of morbidity and mortality when compared with uncomplicated vaginal birth (MacDorman, Declerq et al. 2006; Armson 2007; Liu, Liston et al. 2007).

Etymology

The specific etymology of the term ‘caesarean section’ is uncertain, although all possibilities are focused around the Roman ‘Caesars’. One explanation focuses on the origin of the name ‘Caesar’, first given to one member of one Roman clan – the Julii, whose male descendants thereafter all bore ‘Caesar’ as a surname. It is not known who the first Caesar was, but according to the Roman naturalist Pliny, the cognomen was given to him because he was born ‘a caeso matris utero’ – by cutting the womb of his mother. The words ‘Caeso’ and ‘Caesar’ are derivatives of the Latin verb ‘caedere’ – to cut. Infants surviving the procedure were termed ‘caesones’. The late Roman collection of multi-authored biographies of the emperors of the period 117-284, known as the *Scriptores Historiae Augustae*, also offers three possible alternative explanations for the coining of the term ‘Caesar’. One is that the first Caesar killed an elephant (*caesai* in Moorish) in battle; another is that he had a thick head of hair (Latin *caesaries*), and the third is that he had bright grey eyes (Latin *oculis caesiis*) (Syme 1983). Regardless of its etymology, caesarean section has been recorded as part of the story of childbirth in one way or another since at least the 8th century BC.

The 8th century BC to the 1990s

Justinian I, in his digest of Roman law, wrote a passage that translates as: ‘It is the rule of kings that forbids the burial of pregnant women before the young is excised from their bodies’ (Monro 1904, p.29). This ‘Lex Regia’, or ‘Law of Kings’, is attributed to Numa Pompilius, a legendary king of Rome during the eighth century BC (Monro 1904). The law, which became known as the *Lex Caesarea* (‘Caesarean Law’) under the emperors, stipulated that women who died or were close to death must be delivered in an effort to save the infant.

The introduction of this law was related to religious edicts at the time that required women to be buried separately from their infants. The *Lex Caesarea* also served to address problems about population decline related to the practice of exposing female and “sickly-looking” male infants to death by starvation or drowning (Cantarella 1987, p.115). In response to the decline, the state was trying to increase its number (Dio Cassius year unknown; Tacitus year unknown) and the *Lex Caesarea* was one way of trying to do so (Riccobono, Baviera et al. 1944).

At this point in history, the operation was not performed on women expected to live through childbirth. This casts considerable doubt on the other more popular explanation for the coining of the term ‘caesarean’ – that the procedure was so termed after the surgical birth of Julius Caesar in 100BCE, as depicted in Figure 1. Historical records show that Aurelia (Julius Caesar’s mother) attended her son’s wedding at aged 14 years old to his first wife, and that in later years she received word of his invasion of Britain. Given that the procedure was reserved for dead or dying women, it would seem unlikely that Aurelia gave birth to Julius in this way. This explanation of the etymology of the term is further disputed when it is considered that Aurelia’s husband and Julius’ father, Gaius Julius Caesar the Elder, was already a ‘Caesar’ when they met and married (Galbert and Bey 1988).

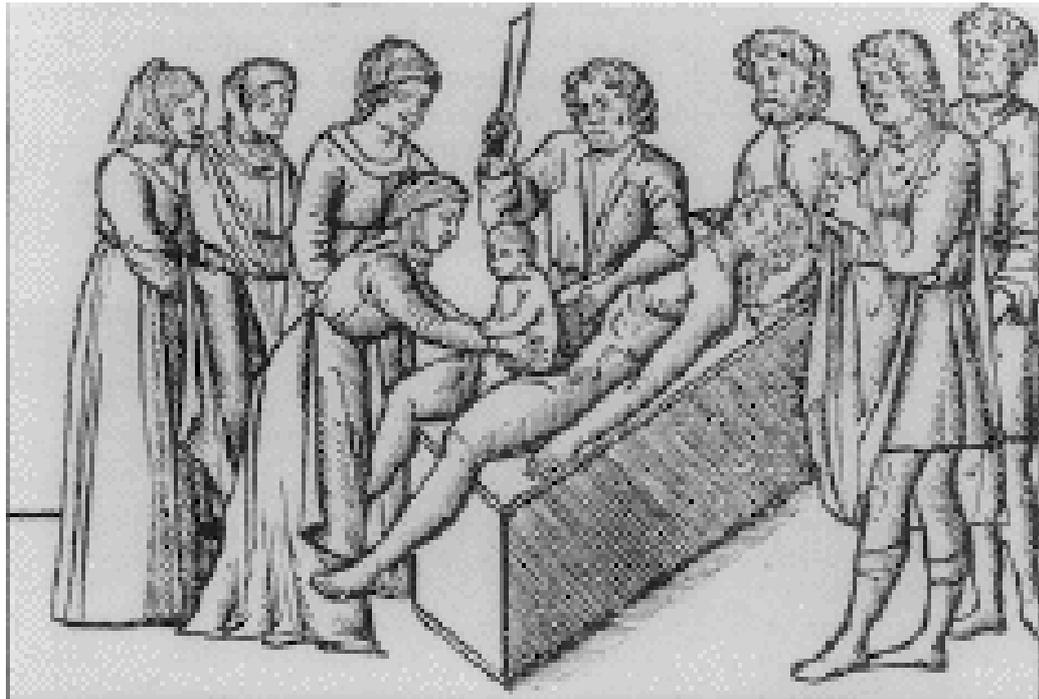


Figure 1. Woodcut depicting a live infant, commonly believed to be Julius Caesar, being surgically removed from a woman (Gaius Suetonius Tranquillus 1957)

Second century AD Greek obstetrician, gynaecologist and paediatrician Soranus, who wrote extensively about complicated births, made no mention of the procedure (Soranus of Ephesus 1991). This supports the argument that caesarean section was most likely performed at this time as a religious-cultural rite rather than as a medical intervention. Around 600 BC an ancient Vedic text places the caesarean section in India. In his 'Sushrita Samhita', the second book of the six-volume 'Charaka Samhita' (the key Ayurvedic medical exposition of the time), the Hindu medical practitioner Sage Susruta describes a caesarean section as the procedure to be performed following the death of a woman in labour. Clearly the motive was to save the child, as it is recommended in the text that the procedure is undertaken as soon as possible after the mother's death on the basis that a delay may result in the death of the child too (Unknown 1949). Likewise, Early Islam custom dictated that in the case of the death of a woman in labour, post-mortem caesarean should be performed (an-Nu'man Date unknown: between 699 and 767 CE), while the earliest known illustration of the procedure was by Islamic astrologer and medical practitioner al-Biruni (Figure 2).



Figure 2. First known illustration of a caesarean section by al-Biruni in the 2nd century AD (al-Biruni date unknown: between 973-1048 C.E.) .

Although caesarean section was seemingly a peri-mortem or post-mortem procedure at this time, there is also the suggestion in Jewish religious texts that, between the 2nd and 6th centuries BC, the procedure was at times also performed on surviving women (Lurie and Mamet 2001). Furthermore, these works allude to women going on to give birth vaginally after a caesarean section, by stating that as a first-born child delivered ‘yotze dofen’ (by coming out of the abdomen) was not recognised as such or given the right of primogeniture; that privilege was reserved for the ‘successive infant born normally’ (Lurie and Mamet 2001).

The likelihood of women giving birth vaginally following a previous caesarean section again is a point of contention, given the surgical techniques of the time. The probability is that if any repair to the incision was attended, it would be only the skin that was closed, not the underlying muscle, the peritoneum or the uterus, as closure of the uterus was not apparently considered until the nineteenth century (Lurie and Glezerman 2003). Prior to then, rudimentary understanding of the contractility of the uterus appears to have deterred operators from suturing it (Boley 1935). If women did survive the surgery to bear a subsequent child, it meant that they had avoided catastrophic haemorrhage, peritonitis and/or endometritis, and that each incision had closed and healed without the assistance of suturing.

Following these ancient records, there is an absence of information about caesarean section until the 14th century AD, from whence a pictorial representation in the form of a French woodcut survives (Figure 3).



Figure 3. Caesarean section performed by a female. (Artist Unknown 14th century)

A post-mortem caesarean section performed in 1305 by French physician Bernard de Gordon is also documented, in which the doctor cites the hope of rescuing the infant for its own sake, rather than the satisfaction of any religious demand, as the indication (Demaitre 1981). This suggests that it was around this time that caesarean delivery started to become the problem of medicine rather than religion. The procedure was still, however, reserved primarily for after the death of the woman at this time, although it this too would soon change. A late mediaeval southern Germany text appears to further support this transition in thinking as it details, in a step-by-step fashion, instructions on how to perform the procedure. These directions are written for the “skillful midwife” when faced with a “sick woman”, and include the need to close the wound with “three or four ligatures by means of a needle and a silk or other thread” (Ketsch 1983, p.273), although further details are not provided. It would seem that possible survival of the woman was anticipated because there is also a discussion of what the midwife should do were the woman to recover consciousness afterwards.

The first account of an identified woman surviving a caesarean section comes from Switzerland in 1500 when a pig farmer, Jacob Nufer, reportedly performed the operation on his wife Elizabeth. The procedure was performed using techniques and tools utilised for the gelding of sows. Reportedly, Jacob sought permission from local authorities to attempt the surgery after Elizabeth spent several fruitless days in labour. Both the woman and the baby apparently survived, and Elizabeth supposedly

gave birth to five more children, including twins, normally. This story was not recorded until 82 years after the event though, and its accuracy has subsequently been questioned (Weber 1971). Reiss suggests that the pregnancy is most likely to have been sited in the abdominal cavity rather than the uterus, asserting that it is inconceivable that any woman undergoing a true caesarean section in such circumstances would have survived, let alone borne more children (Reiss 2003). This argument is strengthened by a number of other documented contemporaneous cases of term extra-uterine pregnancies delivered abdominally (King 1954; O'Dowd and Philipp 1994).

By the middle of the 16th century, knowledge about the human body was increasing, and was shared primarily by illustration. Works detailing anatomy and physiological process began to emerge, so providing a new knowledge base for the health sciences. Andreas Vesalius's general anatomical text *De Corporis Humani Fabrica*, for example, published in 1543, depicts normal female genital and abdominal structures (Figure 4).

Caesarean section is also referred to in R. Jonas's 1540 translation of *Roesslin's Byrth of Mankynde* thus: 'They that are borne after this fashion be called cesares, for because they be cut out of theyr mothers belly, whervpon also the noble Romane cesar the J.(ulius) of that name in Rome toke his name' (Jonas 1540).

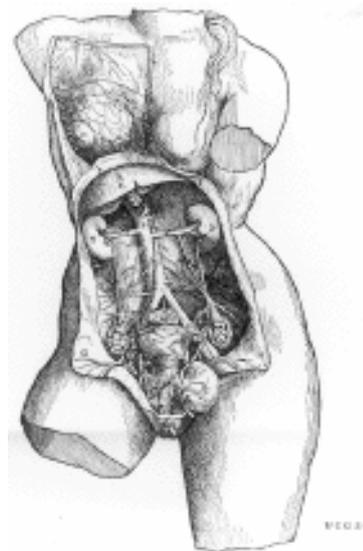


Figure 4. The female pelvic anatomy from Vesalius's *De Corporis Humani Fabrica*, first published in 1543 (Vesalius 2003).

Late 16th century surgeons Ambrose Paré and François Rousset were representative of the first of the ‘man-midwives’ to openly champion the idea of caesarean section in living women for cases of obstructed labour (Quecke 1953; Linker and Womack 1969). Rousset, particularly, promoted the notion of the procedure being performed ‘without prejudice to the life of the (mother) or the (child), nor impairing subsequent pregnancy’ (Quecke 1953, p.26). It was not until the late 19th century however, that the possibility of women surviving the procedure became a realistic expectation.

Italian physician, and Dominican monk, Mercurio’s text provides a detailed and illustrated description of the technicalities of making the incision. Known as the ‘cesarean operation’ until the end of the 16th century, the first requirement of the surgeon was “four strong assistants to hold the woman down” (Mercurio 1596, p.37). The publication in 1598 of Jacques Guillemeau's book on midwifery signalled a change in language. Guillemeau introduced the term ‘section’ (Guillemeau 1609) and increasingly thereafter, the term ‘section’ replaced ‘operation’. For example 17th century physician Helkiah Crooke writes “Concerning this cæsarian section...” (Crooke 1615, p.12).

During the 18th and early 19th centuries, a complexity of factors meant that the landscape of European healthcare changed dramatically. Medical practitioners’ knowledge of anatomy and physiology improved, and with this increased awareness came the increased development and use of anatomically-sympathetic surgical instrumentation (Bennion 1980), including obstetric forceps. Also at this time the provision of maternity care, which had been women’s business and the domain of midwives, was overtaken by the exclusively male medical profession (Donnison 1988).

Empirical scientific understanding was now promoted as the only true and credible basis for practice, and the experiential knowledge, wisdom and craft of midwifery were widely and publicly dismissed by medicine as ignorant, dangerous and inadequate (Schnorrenberg 1981). The fees procured by midwives for attending parturient women are alleged to have added to the medical fraternity’s incentive to commandeer this market (Landry and Maclean 1990). Incidents of disastrous outcomes from medical doctors assisting birth, for example by using forceps incompetently or over-zealously, were reported regularly, however, and many

remained unconvinced of the need to intervene (Boley 1935).

Despite these advances in anatomical and physiological knowledge, it was still maintained that uterine suturing after caesarean section was useless. In fact it was considered harmful, because of the tendency of the uterine muscle to contract postnatally (Levret 1753). As a consequence, mortality remained almost absolute. By 1768, Lebas' suggestion of fifteen years prior, that the uterus should be sutured, was implemented (Field 1988). While the consequence of this measure was a reduction in deaths from haemorrhage, morbidity and mortality from infection increased as the need for asepsis had yet to be discovered (Lurie and Glezerman 2003).

It was not until over a century later that repairing the uterus after caesarean section was popularised by German obstetrician Max Sanger (Sanger 1882). This occurred in tandem with developments in anaesthesia and the aseptic techniques introduced in the two decades prior, and survival rates steadily improved as a result. By 1881 the caesarean section mortality rate had improved from close to 100% in the 18th century, to 75% (Harris 1881; Lurie and Glezerman 2003). By the beginning of the 20th century it was between 1 and 10% (Boley 1935), and by the mid-1940s, just 0.1% of perinatal maternal deaths were associated with the caesarean section procedure (Greenhill 1995). Public and professional perceptions about the operation had now begun to shift.

The new Millennium

The number of caesarean sections being performed worldwide at the beginning of the 21st century is now at an all-time high. This is despite the World Health Organization stating there is no need for any more than 15% of births in any geographical region to be by caesarean section, pending evidence that higher levels benefit either mothers or babies (Joint Interregional Conference on Appropriate Technology for Birth 1985, p. 124). From a rate of around just two per cent in the 1950s (Birth Choice UK Professional 2009), the incidence of caesarean section across the world's most developed countries, where childbearing women are now arguably the healthiest they have ever been, has been calculated at approximately 21% (Betran, Merialdi et al. 2007). In Australia, the rates are among the highest in the world: When last reported, the procedure was performed on 31% of Australian childbearing women annually (Laws, Abeywardana et al. 2007).

While the cause of the rise in the number of caesarean sections has become multifaceted, it would seem that the beginning of the increase occurred concurrently with what has been termed the “malpractice crisis” of the 1980s (Ryan, Schnatz et al. 2005, p.139). Encouraged by the legal profession, consumers began to seek recompense for the life-long cost of caring for children left with residual disabilities thought to be attributable to labour and birth. Accountability for such outcomes came to rest with obstetricians, and after a sudden surge in substantial claims against the profession, malpractice insurance costs soared. In turn, the process of labour and birth was reframed as wayward and hazardous, and in need of control and containment. Obstetricians, who in Australia represent the lead maternity carer for the vast majority of women (Laws and Hilder 2008), seemingly increased their caesarean section rates in response to legal and professional opinion that purported caesarean section as the only certain way to prevent fetal hypoxia (Kirby and Hanlon-Lundberg 1999; Vimercati, Greco et al. 2000; Grant and McInnes 2004; Ryan, Schnatz et al. 2005).

More recent moves to deliver premature neonates anticipated to be of very low birth weight (defined as 1000-1499 grams) and term breech babies by this route have also been implicated in the rising caesarean section rate (Australian Institute of Health and Welfare 2003; Hofmeyr and Hannah 2003). The demographic shift towards women bearing children later in life has also been cited as a contributing factor, as advanced maternal age (particularly being over 40 years of age) has been associated with adverse perinatal outcomes (Qublan, Alghoweri et al. 2002; Jacobssen, Ladfors et al. 2004).

Trends in management of pregnancy after previous caesarean section are also a consideration, as the indication for almost half of the caesarean sections in Australia is having had one previously (Laws and Hilder 2008). This is despite the World Health Organization’s assertion that a previous caesarean section is not in itself an indication for another, and that 85-90% of women with no other complicating factors should be able to give birth vaginally (Joint Interregional Conference on Appropriate Technology for Birth 1985). Statistics for vaginal birth after a caesarean section (VBAC) in many westernised countries, however, remain low. For example, USA perinatal statistics report a national VBAC rate of approximately 9% (Martin, Hamilton et al. 2006). Similarly, only around 15% of Australia women achieve a

VBAC (Laws and Hilder 2008).

Continuous electronic fetal monitoring (CEFM) has also played a part in the rise of the caesarean section rate. Despite its introduction in a vacuum of research as to its effective use, CEFM is perceived by clinicians as the way to identify impending fetal hypoxia during labour. Consequently, the use of CEFM in hospital birth settings is now almost orthodox. CEFM has undoubtedly increased the number of caesarean sections performed (Placek, Taffel et al. 1987), and there is concern that its use incites over-caution as there is little evidence that either it or caesarean sections performed as a result of it have provided any substantive benefits for babies (Enkin, Keirse et al. 2000).

In this climate, the parameters of what constitute 'normal' pregnancy, labour and birth have narrowed, and the threshold for deciding to perform caesarean section has become progressively lower over the last ten to twenty years (Leitch and Walker 2005). It is clear that caesarean section is no longer only a 'last resort' procedure in truly futile or truly dangerous intra-partum situations. Although 'emergency' and 'non-elective' caesarean sections are still performed in these circumstances, the procedure is also now commonly used as an 'elective' preventive measure, wherein it is booked and performed well prior to the onset of labour. According to the medical literature, women's requests for booked caesarean sections in the absence of obstetric indications contribute significantly to this figure. In a recent review of this work, Lobel and Deluca concluded that up to 18% of childbearing women seemingly request the procedure without a physiological indication (2007). Gamble and associates (2007), however, expressed a need for caution in relation to this figure. These reviewers found that research into decision making about elective caesarean section did not account for the way birth options are offered, did not observe the effect of the power imbalance at play in interactions between women and medical practitioners, and did not analyse the cultural context in which decisions are made. Later work by Fenwick and others (2008), which found women to perceive medical discourse as supportive and reinforcing of caesarean section as a safe and responsible choice, confirms Gamble and team's (2007) problems as justified.

The view expounded in the popular press of women who seek to have medically unnecessary caesarean section is commonly that the request comes from those who

consider themselves above doing the undignified work of labour (Shorten 2004; Martin 2007) or are “too posh to push” (Song 2004). Scientific investigation of women’s motives, however, tells a different story. It seems that women’s appeal for a scheduled caesarean is likely related to the obstetric and legal rhetoric of recent times that has posed the natural birth process as unnecessarily risky, and caesarean section as indisputably safer, simpler, cleaner, more civilised and more convenient in comparison (Hamer 2007). Gamble and Creedy’s (2001) investigation into women’s preference for caesarean section, for example, reveals that where women ask for one, it is where they have concluded that vaginal birth is not safe rather than that caesarean section is more dependable. Fenwick and associates’ work on how Australian women reframe birth after a primary unexpected caesarean section (Fenwick, Gamble et al. 2006) also suggests that it is a complexity of issues, including perceived relative safety (both emotional and physical) and the influence of medical discourse, that contribute to women choosing caesarean section again when vaginal birth is a possibility.

It would also seem that, in women for whom childbirth evokes fear and who are already erring towards a decision to deliver by caesarean section, the marketed benefits serve to cement that decision. It does not appear to be that, in themselves, they are a cause for choosing caesarean. Findings from Fenwick and associates’ investigation into women’s experiences of caesarean section, for example, firmly dispute convenience and a desire for a fuss-free birth as the impetus for most women’s choice or agreement to deliver by caesarean section. In addition, long-term feelings of regret and degrees of dissatisfaction with their choice appeared to follow for a large proportion of Australian women who chose (or agreed) to give birth in this way (Fenwick, Gamble et al. 2006).

Implications of caesarean section

This section is concerned with the health implications for mothers’ physiological and emotional health, and for the wellbeing of babies. When compared with vaginal birth, caesarean section has not been demonstrated to contribute at all positively to the overall health and well-being of the majority of mothers and babies. Instead it has been associated with myriad short-term and long-term negative consequences for both (Tatar, Gunalp et al. 2000). A recent review of 79 studies comparing outcomes

of elective caesarean sections with vaginal births leaves no doubt that caesarean section performed for anything other than a life-saving reason carries substantially greater risks than does natural birth (Belizan, Althabe et al. 2007).

Maternal morbidity and mortality

Although scheduled caesarean section has demonstrated some isolated short-term benefits over vaginal delivery - the incidence of urinary incontinence at three months postnatally, for example, has been measured as lower in women delivered by caesarean section (National Collaborating Centre for Women's and Children's Health 2004) - the procedure in low-risk healthy women has been associated with an overall degree of surgery-related severe morbidity or co-morbidities. These include a three-fold increased incidence of haemorrhage, hysterectomy and cardiac arrest compared to vaginal birth (Liu, Liston et al. 2007). The rates of ureter tract and vesical injury and abdominal pain, and placenta praevia and uterine rupture in future pregnancies, have also been demonstrated as greater in comparison to vaginal birth in low-risk women (Belizan, Cafferata et al. 2006). Caesarean section is also noted to be associated with a higher incidence of maternal death compared to vaginal birth (MacDorman, Menacker et al. 2008).

The toll that a large abdominal operation such as caesarean section takes on the body is reportedly enormous, and constitutes a major psychological and physiological stressor (Chernow, Alexander et al. 1987; Salmon 1992). Where a higher-than-usual level of stress is sustained for any length of time, neuro-endocrine and physiological functioning becomes modified, and susceptibility to later disease is increased. The higher concentration of cortisol carried in prolonged stress has been implicated in, for example, cardiovascular disease, depression, obesity and diabetes (Brunner 1997; Brunner and Marmot 1999). Ongoing stress is also known to be associated with immunosuppression, and thus with an increased likelihood of viral and bacterial infection, autoimmune diseases, and cancer (Reiche, Nunes et al. 2004; Wheway, Mackay et al. 2005).

Consequences for neonates

For otherwise-well neonates, caesarean section has been found to confer a near three-fold increased risk of death (MacDorman, Declerq et al. 2006). Neonatal mortality has also been found to be four times higher in infants born by caesarean section when

compared to vaginal birth, although this may be associated with conditions that generated the need for caesarean section rather than the procedure itself (Belizan, Althabe et al. 2007). Effects of the procedure on newborn health and well-being include physical birth injuries such as scalpel lacerations and bruising from forceps, and metabolic, neurological and respiratory maladaptation to extra-uterine life. Deranged blood sugar regulation, transient tachypnoea, reduced alertness, disinterest in breastfeeding and atypical weight loss as a result of delayed initiation of breastfeeding, delayed onset of lactation and impaired maternal milk production have all been associated with caesarean section (Hagnevik, Faxelius et al. 1984; Rowe-Murray and Fisher 2001; Ingram, Johnson et al. 2002; Rowe-Murray and Fisher 2002; Dewey, Nommsen-Rivers et al. 2003; Mears, McAuliffe et al. 2004). As well as the immediate and short-term physiological compromises posed to those born by caesarean section, there is emerging evidence that where mothers are anxious before or during birth, the hormonal effects on neonatal neural pathways may account for a spectrum of emotional and behavioural issues in the later life of these offspring (see for example O'Connor, Ben-Shlomo et al. 2005).

Emotional wellbeing

The growing body of knowledge related to adverse mental health outcomes for women after childbirth is demonstrably linked with the type of maternity care received and the occurrence of interventions, such as caesarean section (Menage 1993; Ryding, Wijma et al. 1998; Creedy 2000; Fenwick, Gamble et al. 2003). The most well known and recognised mental health risk related to operative delivery is postnatal depression (PND). Research indicates that between 10-15% of childbearing women suffer PND, but that twice as many women develop the condition after an unexpected caesarean section compared to those who give birth vaginally (Koo, Lynch et al. 2003). Similar findings have also been reported cross culturally (Alvarado, Perucca et al. 1993; Astbury, Brown et al. 1994; Fisher, Astbury et al. 1997; Ukpong and Owolabi 2004; Agoub, Moussaoui et al. 2005). Delay in mother-baby contact, which commonly occurs with caesarean section, has also been associated with a higher Edinburgh Postnatal Depression Score (EPDS) both in the very early postnatal period (2 days) and at 8 months postpartum (Rowe-Murray and Fisher 2001).

Post-traumatic stress disorder, also known as 'shell-shock', a condition more often

found in victims or witnesses of conflict, torture and disaster, has more recently been related to childbirth. Research demonstrates that internationally, between 24% to 34% of childbearing women experience what have been described as 'birth-related traumatic stress' symptoms at 6 weeks postpartum (Olde, van der Hart et al. 2005). Again, the incidence of birth-related traumatic stress is seemingly higher in women who experience childbirth intervention such as caesarean section (Creedy 1999).

Literature also exists reporting the health implications for the infants of women who have experienced traumatic stress around the time of parturition. Yehuda and Bierer (2009) found lower salivary levels of cortisol in neonates borne of mothers who experienced an episode of traumatic stress during pregnancy in comparison to those borne of mothers who had not. Cortisol is the hormone that helps to regulate blood pressure, cardiovascular function, and the metabolism of proteins, carbohydrates, and fats, at birth. It is thought that exposure to stress in utero affects the developmental programming of the tissue structure and function responsible for cortisol production and metabolism in the fetus and through into adulthood. In addition, the body of work on gestational programming and epigenetics suggests that the offspring of a parent who has experienced traumatic stress are far more likely to have a similar response to testing situations than the offspring of never-traumatised parents are (Nugent, Amstadter et al. 2008).

The symptom profile of some women emotionally affected by an unhappy or distressing birth experience closely correlates with that of an acute grief reaction (Kim and Jacobs 1991). It occurs as a consequence of the incongruence between the desired and the actual birth, and of the apparent inability to independently and safely give birth to her own baby (Hynan 1996; Tully 2003; Madsen 2004). Grief, regret and despair are closely related to hopelessness (Cutcliffe 1988), the continued state of which is known to be the primary indicator for suicidal intent (Wiesharr and Beck 1992). This is particularly relevant given that the Australian Institute of Health and Welfare (AIHW) has identified suicide as a leading cause of indirect maternal death in Australia (Slaytor, Sullivan et al. 2004). Of the 28 indirect maternal deaths reported in the period covered by the report, eight were successful suicides. Similar findings have also been reported in the United Kingdom (Royal College of Obstetricians and Gynaecologists 2002).

Poor postnatal health has consequences for a woman's transition to parenthood and her role as a mother, as well as for her interpersonal parental relationships (Ogrodniczuk 2004). Sub-optimal maternal mental health has been demonstrated as detrimental to family health, interactions, functioning and parenting (Mutryn 1993; Burke 2003). Infants and children in affected families are undoubtedly at increased risk of developmental difficulties (Sinclair and Murray 1998; Hay, Pawlby et al. 2001; Murray, Cooper et al. 2003), and the impact of maternal mental ill-health on the well-being and development of children within the family can be devastating (Kendall and Li 2005). Children of women who suffer mood disorders, for example, can have long-term emotional, behavioural and cognitive developmental disturbance (Field 1992; Murray 1992; Sinclair and Murray 1998; Rowe-Murray and Fisher 2001).

Suboptimal individual and family functioning and resilience also has a considerable impact on the wider community, as the economic costs to society are significant (Willms 2002). Sufferers of any form of emotional distress can require extended health care for both their psychological condition, and for subsequent physical illnesses which may arise as a result (Webster, Linnane et al. 2000; Dennis 2004). In the UK in 2002, the economic cost of caring for a mother with PND was calculated as equivalent to at least \$A1,000 more than the cost of caring for a psychologically well mother (Petrou, Cooper et al. 2002).

While there is a comprehensive body of evidence reporting the implications and possible sequelae of both unnecessary elective or non-elective caesarean section and emergency intra-partum caesarean section, however, knowledge about the outcomes of medically necessary elective caesarean section remains scant.

Preliminary literature review

As mentioned previously, researchers utilising the Grounded Theory methodology have been cautioned away from surveying the extant evidence prior to collecting data. This based on the premise that the emergent theory must, as far as possible, be grounded in the data rather than in conscious or unconscious preconceived impressions gleaned from the work of others. It has been asserted by many that concepts within the existing literature should earn their way into the theory, and that prior work should be utilised only to confirm, refute or otherwise contextualise

emerging findings (Glaser 1978; Stern and Allen 1984; Lincoln and Guba 1985; Strauss and Corbin 1994; Hickey 1997; Charmaz 2006). Others, however, have suggested that a preliminary review of the literature can provide a focus for the study, identify gaps within the existing body of knowledge, and prove the need for and significance of the study to be conducted (Hutchinson 1993; Patten 2002). It was on this basis that the following preliminary literature review was conducted.

Over the first two weeks of July 2006, extensive searches of the 'PubMed', 'PsychInfo' and 'CINAHL' databases, as well as of individual social science, nursing and midwifery journal back catalogues, were conducted using the key words 'elective', 'planned', 'booked', 'cesarean', 'caesarean', 'cesarian', 'caesarian', 'abdominal', 'section', 'birth', 'delivery', 'perceptions' and 'experience' in various combinations. Only five papers within the last 20 years reporting research conducted with women needing a planned caesarean section were identified. The paucity of work was later confirmed by Lobel and DeLuca in their review of the literature related to the psychosocial sequelae of caesarean section (2007). Four of the identified studies utilised quantitative methodologies, while the fifth took a qualitative/explorative approach.

Of the four quantitative studies, only that by Schindl and associates (2003) investigated women's total experience of caesarean section. This large Austrian quantitative study used a self designed questionnaire and a variety of well-established instruments to measure mood, emotions and attitudes of 1050 pregnant women at 38 weeks gestation, and then later at three days and at four months postpartum. It found that women who had given birth by caesarean section scheduled for medical reasons scored highest for negative feelings about their birth experience at four months postnatally, when compared to women who had a normal or assisted vaginal birth or an unplanned, emergency or 'maternal request' caesarean section.

Stadlmayr, Schneider, Amsler, Burgin and Bitzer (2004) investigated the possible influence of obstetric variables on German women's birth experiences. Validated for use with German women, the 20-item Salmon Item List (SIL-Ger) measured four dimensions of the birth experience, namely emotional adaptation, physical discomfort, fulfilment and negative emotional experience. Following administration of the instrument to 251 randomly selected primiparous and multiparous women at

48-96 hrs post birth, the results of the step-wise regression analysis revealed that the variables of induction of labour, parity, infant's sex, birth weight and umbilical ph measurements had no effect on any of the four dimensions. Mode of delivery was, however, found to affect emotional experience, with women reportedly feeling far more cheated and/or disappointed after instrument-assisted vaginal birth, elective caesarean section and unplanned caesarean section than they did after spontaneous vaginal birth. A limitation of this study was that caesarean section for maternal preference or request was not reported separately to caesarean section for medical indication. The authors concluded that elective (scheduled) caesarean section is associated with higher levels of negative emotional experience in the immediate postpartum period when compared with vaginal birth.

Work undertaken in the United Kingdom by Keogh, Hughes, Ellery, Daniel and Holdcroft (2005) was the third piece of research retrieved. In this study, the investigators examined the psychosocial influences on 65 primiparous and multiparous women's experiences of planned ('elective') caesarean section. Questionnaires were completed by women as well as their birth partners at 36 weeks of pregnancy, on the day of the caesarean section, and at one to four days post-natal. Women's expectations of caesarean section, anxiety and fear and those of their birth partners were measured, as was women's post-natal pain. Analysis indicated a relationship not only between women's antenatal and intra-partum expectations and fear and their post-natal pain, but between their birth partners' antenatal and intrapartum fear and anxiety and women's post-natal pain. Although women within the two sub-categories of planned caesarean section (that is, maternally requested and medically indicated) were not studied separately, the research demonstrated how the anxiety of a significant other can impact on women's planned caesarean section and post-operative experience. This research was the only piece of work found that was concerned with women's information needs and with the influence of the birth partner on women's experience. It also examined the role of health care professionals in relation to psychological and emotional health needs of women giving birth by planned caesarean section. The authors concluded that antenatal interventions that address women's and partners' caesarean section birth fears and anxiety should be considered for their potential negative impact on the postnatal experience.

The fourth piece of relevant work retrieved from the literature search was the meta-

analysis undertaken over a decade ago (DiMatteo, Morton et al. 1996). This extensive and well-written review examined the influence of vaginal and caesarean birth on 23 measurable psychosocial outcomes for women's health. In their own review of the literature, Di Matteo et al were only able to find one paper, an American study, in the original 74 empirical studies they considered for review and analysis that was concerned with scheduled caesarean section (Cranley, Hedahl et al. 1983). In this study, Cranley and colleagues (1983) found that women's postnatal perceptions of their birth experience were associated with the level of participation in decision-making about and during childbirth. At two to four days after birth, women having no choice but to give birth by an elective caesarean section reported significantly more negative perceptions of their birth experience than women who gave birth vaginally. This analytical review probably still represents the most recent comprehensive appraisal of the literature around this phenomenon to date.

The fifth paper retrieved from the preliminary literature search reported a qualitative investigation into women's post-natal perceptions of caesarean section under regional anaesthetic (Ying, Levy et al. 2001). As this paper so closely resembled the theme of the proposed study, I made a decision not to read it. This decision was based upon a wish for my interviewing and data analysis to remain as free of pre-conceived influences as possible, and to reduce any possible likelihood of conscious or unconscious 'forcing' of the data and categories (Glaser 1992).

Summary

In this Chapter, caesarean section has been chronicled through history and located within the childbirth paradigms of the ages. What is known of the health implications of the procedure for women and babies has also been reported. Additionally, it has been established that the current climate within which women are bearing children renders it increasingly likely that caesarean section will be recommended to them during pregnancy for health reasons.

In the following Chapter, the scientific paradigm and the specific methodology employed for an investigation into women's experience of caesarean section scheduled during pregnancy for health reasons is presented.

Chapter 3

Taking a Glaserian Approach to ‘Doing’ Grounded Theory

We are not saying there is only one way to do research, or that our way is best, or that the so-called old ways are bad. We are just saying this is one way to conceptualize this field, and it is a way that we find useful.

Norman Denzin and Yvonna Lincoln (2005)

Introduction

This chapter presents how a study of 28 Australian women’s experience of a caesarean section scheduled during pregnancy for health reasons was conducted using the Glaserian Grounded Theory methodology. To introduce the concepts important for understanding Grounded Theory, two opposing research paradigms – the quantitative and the qualitative approach - are outlined and contrasted. The background, origins and paradigm location of Grounded Theory are then described. The discussion then moves on to outline the key tenets of the methodology, before the ways in which the original version has subsequently been developed are considered.

My selection of a qualitative approach for this investigation, specifically Glaserian Grounded Theory, is then justified, before the investigative processes are briefly described. To follow, the investigative processes I followed are detailed. The research question and objectives are identified, and the study setting is presented. Participant sampling, participant recruitment, bracketing, ethical considerations, data collection, data analysis (including the pursuit of data trustworthiness) and theory generation are all explained in depth within the context of four stages of Grounded Theory investigation.

Positivism vs. naturalistic interpretivism

Since the emergence of Dewey’s work investigating human nature and conduct in the 1920s (Dewey 1922), two primary scientific paradigms have existed. Commonly these are referred to as the positivist and the naturalistic, or interpretivist paradigms

(Goulding 1999; Polit and Beck 2006). The positivist paradigm is founded in a belief that there is one true existent reality, which consists only of what can be empirically observed and measured. Positivist logic values objectivism, and asserts that thought, feeling and emotion bear no relevance to how reality 'is' (Markie 2004). Research within the positivist paradigm is primarily conducted using quantitative methods - a system of describing, explaining and predicting naturally-occurring phenomena so that the conclusions drawn may be generalised to other persons and places. Data are gathered through objective observation and measurement, and eradication or minimisation of 'contamination' of the data through personal involvement with the research subjects is paramount. The ability to replicate the research exactly is also sought.

In contrast to the positivist view, the naturalistic paradigm acknowledges and accepts humans' interpretations of reality as an integral part of that reality. Individual perceptions and expressions of personal awareness are valued. By extension, the naturalistic view is that we each experience reality differently, and that the world is made up of multiple realities (Krauss 2005). In such a world, nothing about those realities can be deemed false or untrue, nor can findings be measured in mathematical terms, or generalised (Taylor, Kermode et al. 2006). Within this worldview, qualitative research is employed to investigate the subjective experience and behaviour of the whole person, including all of the influences brought upon it by dynamic interaction with the situation or environment. For example, the researcher is considered to be just another influence on a particular reality, and is largely embraced as such (Streubert Speziale and Carpenter 2003). As the broad aim of naturalistic study is to "...clarify the multiple dimensions of a complicated phenomenon..." (Polit and Beck 2006), a qualitative approach to discovery is very useful when little is known about a particular phenomenon (Morse and Field 1995).

A number of different qualitative methodologies exist, and may be construed as either interpretive, for example Grounded Theory, Phenomenology, Ethnography, or critical, for example Action Research (Taylor 1995; Rapport 2003). Furthermore, variations to and departures from each methodology reflect differing philosophical bases of and departures from each, such as is the case with Heideggarian and Husserlian Phenomenology (Sokolowski 2000). All, however, are defined as qualitative because of their abiding subscription to a number of common assumptions

and attributes. Streubert-Speziale and Carpenter assert that these are six in number, and identify them as a belief in multiple realities, a commitment to identifying an approach to understanding that supports the phenomenon studied, a commitment to the participant's viewpoint, the conduct of inquiry that limits disruption of the natural context of the phenomena of interest, acknowledged participation of the researcher in the research process and the reporting of the data in a literary style rich with participant commentaries (2003, p.16).

Insofar as it reflects these values and traits, the Grounded Theory methodology could quite comfortably be positioned within the naturalist interpretive paradigm as a qualitative methodology, and indeed, it most often is. Although Goulding (1999) ultimately comes to this same conclusion, she cautions that Grounded Theory methods have also been perceived as pseudo-positivistic. This, Goulding states, is because the “attempts to structure, order and interpret data are commonly seen to defile the canons of pure qualitative research”. Mills, Bonner and Francis (2006, p.3) support this argument; they propose that when Glaser, one of the Grounded Theory methodology's founders, talks of “...the discovery of *the* truth that emerges from data representative of *a* ‘real’ reality” (my emphases), he assumes a positivistic assumption of a single unitary reality. Goulding (1999) maintains her position however, and on the basis that it represents an extension of the methods used in Symbolic Interactionism, argues strongly for the inclusion of Grounded Theory as a qualitative methodology within the naturalist interpretivist paradigm. Goulding's position echoes that of a number of others (see for example Wilson and Hutchinson 1991; Robrecht 1995), and it is from this stance that I also choose to regard it. A description of the original form of Grounded Theory (Glaser and Strauss 1967) now follows. This includes information about the methodology's origins and background, as well as an overview of subsequent methodological developments.

Grounded Theory methodology

Grounded Theory methodology has, for the past 40 years or so, offered researchers a systematic way of collecting, organising and analysing data for the purpose of generating theory. It has been identified as a “comprehensive, integrated and highly structured, yet eminently flexible process that takes a researcher from the first day in the field to a finished written theory” (Glaser and Holton 2004). Perhaps confusingly,

the term 'Grounded Theory' applies to both the methodological process employed, and the outcome. In its earliest form however, the methodology was known simply as comparative analysis, while the product was known as the Grounded Theory (Glaser and Strauss 1967). The techniques were developed by American sociologists Barney G. Glaser (b. 1930) and Anselm L. Strauss (b.1919, d.1996) while working together on a study of the experience of dying in hospital at the University of California at San Francisco (Glaser and Strauss 1965; Glaser and Strauss 1968). Following completion of the study, the investigators presented their methodological strategy as one that could be applied across the social sciences (Glaser and Strauss 1967).

Background and origins

According to Glaser and Strauss themselves, they each made a unique but complementary contribution to the Grounded Theory methodology (Glaser and Strauss 1967). Strauss' perspective allowed for the exploration of the social and psychological processes that occur through interaction. Glaser provided "...a systematic set of procedures to develop a theory of the dominant social processes about a phenomenon...from the data collected about that phenomenon" as a way of quantifying and explaining these interactions (Streubert Speziale and Carpenter 2003, p.107).

Despite having very different backgrounds, Glaser and Strauss made it clear early in their seminal text 'The Discovery of Grounded Theory: Strategies for Qualitative Research' (1967) that the meeting of their minds was largely due to a shared conviction that not just their own, but all post-war sociological traditions thus far, had been wholly unsuccessful in generating theory that was "useful" and "relevant" (Glaser and Strauss 1967, pp.vii and viii). The system developed by the two sought to redress this, and to provide social scientists with a revolutionary new practical, yet rigorous, stepwise approach to conducting qualitative research and developing theory. If conducted with sensitivity to the data, this new approach promised to deliver theories which fitted the substantive area, and that were readily understandable, 'generalisable', and modifiable (Glaser and Strauss 1967 pp.237-249). Although the methodological principles of Grounded Theory application have their basis in objectivist positivist concepts, these are executed in an interpretivist context, specifically that provided by symbolic interactionism (SI).

SI originated in the late 19th and early 20th centuries from the work of both the German economist and sociologist Max Weber (b.1864, d.1920) and the American philosopher George Herbert Mead (b.1863, d.1931). In observing and studying human group life, both Weber and Mead emphasised the subjective meaning of humans' behaviour and the social process. Herbert Blumer, a student of Mead's at the University of Chicago, crystallised the approach, and is credited with attributing the theory with the label 'Symbolic Interactionism' (Smyth 1997; McClelland 2000).

Blumer (1969, p.2) stresses that SI rests on three simple premises. The first is that human beings act toward things on the basis that meanings have for them, the second is that the meaning of such things is derived from, or arises out of, the social interaction that one has with one's fellows, and the third is that these meanings are handled in, and modified through, an interpretative process used by the person in dealing with the things he encounters.

In SI terms, society is considered to be founded on transactions between individuals, humans are viewed as active and creative participants who construct their own world and human behaviour and human interaction is purported to be motivated by interpretation of environmental signs and symbols. This process of interpretation leads humans to ascribe meaning to such signs and symbols, which in turn affects behaviour (including interactive behaviour) in that environment. To confound the issue, meaning ascribed to a sign or symbol is highly individualised, and is often dependant on context (Streubert Speziale and Carpenter 2003; Tuckett 2005). SI research observes face-to-face interactions between individuals (McClelland 2000) and analyses them to interpret life and human conduct (Blumer 1986).

Embedded within the SI-based perspective of the Grounded Theory methodology are principles and systematic steps for building theory. These are based on the principles of qualitative mathematics and the concepts of index formation that Glaser was exposed to as a student of Paul F. Lazarsfeld (b.1901, d.1976) at Columbia University (Merton and Coleman 1979; Strauss and Corbin 1998, p.10). The empirical social research model developed by Lazarsfeld, a mathematician and sociologist, is demonstrated in his seminal investigation into the effects of unemployment in a Viennese village during the 1930s (Lazarsfeld 1932; Eisenberg and Lazarsfeld 1938; Jahoda 1987). In contrast to any other approach at the time, the

study employed a wide variety of techniques to collect information on individuals and families from many sources. Data collected included, for example, biographies, time usage sheets, official complaints and declarations, essays from school children, inventories of meals, themes discussed in pubs, and the type of Christmas presents given. Current and historical statistics, demographic data, and personal experiences of illness were also obtained. Through the careful and systematic analysis and distillation of this richly diverse material, the investigators were able to 'diagnose' the essential problem facing the community, which was that it was 'müde gemeinschaft' ('tired and exhausted') (Jahoda 1987). This process also revealed the underlying and hidden elements upon which the dissipation of individuals' identities as a result of long-lasting unemployment depended.

Lazarsfeld's techniques and approach to data collection and analysis were aimed at the discovery of the essential (or 'core') human problem, and the revelation of the human processes around that problem. These became, and remain today, the key tenets of the Grounded Theory methodology (Glaser 1978; Polit and Beck 2007).

Objectivist vs. Constructivist Grounded Theory

In response to criticisms of the original incarnation of the Grounded Theory methodology, specifically that it was "loose, lacking verification and had a tangled description" (Stern 1994, p.220), Glaser and Strauss individually undertook to develop it further. Glaser maintained, and has continued to espouse, a steadfast commitment to the methodology as it was originally conceived. He has developed it only insofar as to describe its steps and their rationale more explicitly (see for example Glaser 1978; Glaser 1992). Strauss, meanwhile, along with nurse researcher Juliet Corbin moved to simplify, describe and prescribe the methodological steps (Strauss and Corbin 1990), and to provide a framework within which theory should be constructed. This is despite his and Glaser's original concern that over-systematisation would curb rather than encourage creativity (Glaser and Strauss 1967, p.8).

According to Stern (1994, p.220), Strauss and Corbin's attempt to make the methodology more understandable and accessible modified it too far, so that it became strictured and little more than an exercise in dense codification. Glaser, too, claimed that this approach lead simply to rich description, and added that it favoured

the analyst's interpretation of the situation over the subjects' experience. He has maintained that this, nor any other variation of the original, could be called Grounded Theory (Melia 1996; Glaser 1999; Glaser and Holton 2004).

This methodological divergence has provided the source of much debate. Most extensively, the discourse centres upon which of the two founders has remained most faithful to their original intent, which was to provide a means to develop theory from data (see for example Heath and Cowley 2004). In the last decade, the deliberations have extended to include and consider the validity of Constructivist Grounded Theory, a methodological variant which builds on Strauss and Corbin's version (Mills, Bonner et al. 2006).

Constructivist Grounded Theory was proposed by American Sociologist Kathy Charmaz (2000) in response to her disagreement with the Objectivist stance and Positivistic values that she views Glaser and Strauss as promoting. Charmaz's version openly acknowledges and values the researcher's thoughts, feelings, and knowledge as data to be considered equally with other data. The Constructivist assertion is that theory construction is mutual, and that the resultant Grounded Theory is reflective of both the participants' and the researcher's reality.

The argument around methodological variants is confusing for the beginner as it appears there are many fine points of contention. The argument, however, is seemingly fixed around how and from where the resultant theory emerges, and what it looks like. The Constructivist view rejects the notion of both objectivity and emergence (Mills, Bonner et al. 2006), and rather supports the principle that "the 'discovered' reality arises from the interactive process" (Charmaz 2000, p.524). The Objectivist view though, wholly rejects Charmaz's assertion that "researchers are part of what they study, not separate from it" (Charmaz 2006, p.178). In contrast to the Constructivist view, Objectivist Grounded Theorists take the stance that the interpretation of data is not "mutually built up"; according to the Objectivists, the acknowledgement of the researcher's reality in data analysis and theory building represents "an unwarranted intrusion" (Glaser 2002, p.2).

While no stance has been publicly made in response to Constructivist Grounded Theory by the now-deceased Strauss or by Corbin, it has been overtly dismissed by Glaser as no more than Qualitative Data Analysis that results only in literal

description. Taking a whole book to detail his objections, Glaser clarifies his position that unless researchers stay faithful to the original ‘package’, their work cannot be called Grounded Theory (Glaser 1992; Melia 1996; Glaser 2002; Flint 2005).

Selecting Glaserian Grounded Theory

The original version, now known as the Glaserian variant, of the Grounded Theory methodology, was selected as most appropriate for investigating and theorising the women’s experiences of a caesarean section scheduled during pregnancy for a health reason. I chose this variant of this methodology for its proven ability to reveal hitherto unexplored phenomenon, and because it would enable the development of a theory which would reflect and honour the participating women’s own reality.

Confirming the need for a qualitative approach

To decide how to most effectively answer a research question or explore a phenomenon of interest, convention dictates that first, the nature of the problem and the focus of the inquiry are clearly identified (Strauss and Corbin 1998; Streubert Speziale and Carpenter 2003). This is not the case, however, when using Grounded Theory methodology. According to Glaser, the researcher must move into an area of interest without a specific problem in mind, in order to have an “abstract wonderment of what is going on that is an issue, and how it is handled” (1992, p.22). In the investigation reported in this thesis, the processes of selecting the methodology and of identifying the area of investigation occurred concurrently.

In the first instance, anecdotal comments made to me by women anticipating a caesarean section necessary for health reasons moved me to want to find out more about their experience. A preliminary literature search, detailed in Chapter Two, revealed a body of work about how women reacted to non-elective and emergency caesarean section, however I could find very little reported about how women responded to and negotiated their experience of caesarean section when scheduled during pregnancy for health reasons. This paucity of information meant that there was no body of work available upon which to mount a quantitative investigation (Polit and Beck 2006). A study conducted through a qualitative approach, which would lend itself to “finding out what people are doing and thinking” (Strauss and Corbin 1998, p.11) therefore seemed most appropriate for investigating this issue. Although qualitative methods can be used to gain novel understandings of

substantive areas about which much is already known, they are most valuable in exploring those areas about which we know little (Stern 1980).

Identifying with the Glaserian perspective

According to Woodgate (2000, p.194), all approaches to qualitative research (and by association, all qualitative researchers) “share a similar goal, in that they seek to arrive at an understanding of a particular phenomenon from the perspective of those experiencing the phenomenon”. In addition, the decision to work within a specific variation of a particular qualitative approach appears to be based on two considerations. While Streubert Speziale and Carpenter assert that the choice of method should depend only on what the question being asked is (2003), Strauss and Corbin acknowledge that researcher temperament, orientation, preference and experience of the investigator(s) also have a significant influence on the decision (1998). In my case, both considerations were factored into my decision.

I chose to conduct this Grounded Theory study using the Glaserian version (also known as the traditional version, or the original version) of the methodology for two main reasons. Firstly, I felt confident that I would be able to approach the substantive area, the participants, the data, and theory development with a high degree of objectivity. This confidence was a consequence of my professional experience. Arguably, the first value of both nursing and midwifery is that they are practised from a non-judgmental stance; people and their situations are regarded and valued unconditionally by those in caring professions (Rogers 1959). At the time of undertaking this study, I had spent sixteen years in a wide variety of nursing and midwifery environments, which imbued me with a very well-developed understanding and experience of practising unconditional regard. I would consider myself well able to engage, in a non-subjective way, with all people in all situations. On this basis, I fundamentally disagree with Charmaz’s assertion that it is not possible for the researcher to “stand outside” (2006, p.130), and identify strongly with Glaser’s maintained conviction (Glaser and Holton 2004) that it is.

Secondly, the Glaserian version of the methodology was, to me, more clear and straightforward than the Straussian and the Charmazian versions. I found them, respectively, too detailed, restrictive, and ambiguous. I felt an empathy with Glaser’s approach immediately. Although Glaser’s “abstract terms and dense writing” have

been criticised as “inaccessible” (Glaser 2002, p.4), I did not find this to be the case. Also, the subsequent explorations and explanations of the various aspects of Glaser’s version of the methodology that has been provided over the years (for example Glaser 1978; Glaser 1992; Glaser 1992; Glaser 1998; Glaser 2001) meant that I was able to ‘get to know’ this version of Grounded Theory more thoroughly. In contrast, the Straussian and Charmazian versions both left me with many unanswered questions about their application.

The methodological processes of Grounded Theory

The purpose of Glaser and Strauss’ Grounded Theory methodology was to enable the development of a theory that conceptualised the meaning of experience and behaviour (Sidani and Sechrest 1996). Consistent with the interpretivist worldview that reality consists of multiple perspectives, Grounded Theory researchers are urged to collect data from a variety of sources. The wide range of perspectives gained from doing so enables the construction of a model that reflects a consensual view of reality (Schreiber and Stern 2001).

The process of arriving at the Grounded Theory itself is not linear, but circular. The researcher moves forwards and backwards between data collection, data analysis and theory generation. All stages are performed simultaneously and reflexively within the constant comparative, or constant comparison method (Glaser and Strauss 1967; Flint 2005). Constant comparison entails an ongoing cycle of induction and deduction, and is said to form the corner stone of the process of Grounded Theory analysis (Streubert Speziale and Carpenter 2003). In short, constant comparison involves the assessment of new data, as it is collected, against that already obtained. This activity enables theory development to happen while data collection is in progress rather than after collection of the data set is complete.

From the outset, the Grounded Theory researcher strives to pinpoint how the participants’ realities are most simply and succinctly characterised and explained. The overall aim of a Grounded Theory is to explain “what is going on” from the participants’ perspective (Glaser 1998, p.25). This explanation, according to Glaser and Strauss’ original methodology, is attained through performing four research stages through which constant comparison is threaded. Briefly, the four cycling/concurrent stages of original Grounded Theory are,

1. Purposive sampling, initial data collection, open coding, categorisation of codified data, theoretical memoing, identification of the core category (that is, the problem facing the participants) & the basic (responsive) process
2. Category refinement: categorical property definition, selective sampling, theoretical memoing
3. Category refinement: reduction/parsimony and scope, selective/theoretical sampling, theoretical memoing
4. Theoretical memo sorting, writing up the theory (Glaser and Strauss 1967 p. 104).

The application of these processes in the research study reported in this thesis is now described.

Sampling, recruitment and data collection

According to Glaser and Strauss, identification of the gross features in the substantive area of investigation will suggest where or to whom the researcher must look for data (1967, p.45). The aim of sampling and data collection in this study was to ensure sufficient density and multiple perspectives for the full illumination of the social phenomena under study (Hutchinson 1993). The requirement to sample thus within the Grounded Theory methodology allowed for data collection from many different sources, with no limits set on the range or number of data sources accessed (Stern 1980; Cutcliffe 2000). In the study reported here, five forms of data were collected. These included semi-structured interviews with women before and after their caesarean section, non-participant observations of the operating theatre environment during scheduled caesarean sections, semi-structured interviews with women's partners before and after their partner's caesarean section, semi-structured interviews with hospital-based health care professionals involved in caring for this group of women, and field notes.

The setting for the study was an Australian tertiary maternity hospital. Apart from caring for women with complicated pregnancies, the hospital also provides care for local women with healthy pregnancies and healthy babies. Broad socio-economic and cultural diversity is represented in the unit's clientele. In the years over which the majority of the study data was collected, approximately 5,500 births occurred at the hospital. During this time, an average of 34 scheduled caesarean sections per month were performed on women with term pregnancies.

Sampling

Two forms of sampling were utilised in this study. Purposive sampling, a non-probability sampling method in which the researcher selects any participants within that exposure (Polit and Beck 2006), was used first. Then, as data analysis and theory development progressed, sampling became what Glaser terms “theoretical” (Glaser 1978, p.36), that is, only information that was relevant to the emerging theory was sought.

As the phenomenon of interest was the experience of scheduled caesarean section, pregnant women who were anticipating this procedure, and those close to and caring for them, were the most obvious sources of information. The first purposive sample was formed of pregnant women attending the antenatal clinic at the hospital, who on health grounds had been scheduled during their pregnancy to give birth by caesarean section. The second purposive sample was formed of hospital-based health care professionals who contributed to the care of this group of women. The third purposive sample was formed of the participant women’s partners.

Inclusion and exclusion criteria

For women, only two inclusion criteria were stipulated: the first was that they must have been anticipating their first caesarean section regardless of parity. The second was that the caesarean section must have been initiated by a healthcare practitioner and scheduled for a health reason, rather than requested by the woman herself. Five exclusion criteria were identified for women, and included i) being younger than 18 years of age - the age at which a person is deemed a competent adult in Australia, ii) being unable to comprehend and converse in English, iii) being unwilling or not consenting to participate, iv) certain knowledge that the baby would be seriously unwell, would die or would be already dead at birth, and v) being deemed as unsuitable to participate by their attending clinician(s). For health care professionals and women’s partners, the only inclusion criterion was a desire to participate. No exclusion criteria were set for these purposive samples.

Recruitment of participant women

All women who had been scheduled for a caesarean section because of a health reason were identified through the appointment list for the caesarean section pre-admission clinic (PAC), held at the hospital every Tuesday. Women identified as

eligible for the study were then approached during their appointment at the PAC. For most women attending this appointment, their caesarean section was scheduled in the following seven days.

The two to three hour PAC appointment offered an ideal environment for participant recruitment. This was because during this appointment, women were required to wait for periods of up to 20 minutes between each of three consultations with a midwife, an anaesthetist and an obstetrician. These twenty minute time periods provided me with sufficient opportunity to approach eligible women, give them written and verbal information about the study, start to establish a rapport, and provide them with my contact details. I gave each woman an information sheet (see Appendix 1), asked if I may telephone the next morning to see if they would like to participate, and obtained a contact number for those women who agreed.

As some women scheduled for a caesarean section bypassed the PAC through already being a hospital in-patient, I also displayed information posters in the wards, in the hope that some women might self-select for the study. These women were also given written and verbal information, and followed up on the ward the next day with their permission.

Consent was sought from women for me to formally interview them antenatally and postnatally (and to digitally record the interviews). Women were also asked to permit me to attend their caesarean section as a non-participant observer, although it was made clear that this was not essential. Consent was documented as verbally obtained for interview and for observation if, when contacted the following day, women agreed to participate. Written consent was then obtained when I met with each participating woman for the antenatal interview (see Appendix 2).

Recruitment of health care professionals

In the weeks prior to data collection, brief in-service information sessions were held for staff in all relevant clinical areas. In addition, posters were displayed on notice boards in all clinical and staff socialisation areas. Through both forums, health care professionals were invited to contact me if they would like to take part in a one-off, semi-structured interview for the study. Written and verbal information was provided to interested personnel (see Appendix 1 for the information sheet). I asked each if I may contact them the next day to see if they would like to participate, and obtained a

contact number of those who agreed.

Staff who agreed to participate when contacted were asked to name a convenient day, time and place for the semi-structured interview to take place. Written consent (see Appendix 2) was then obtained at the time of meeting. All health care personnel who consented to participate requested the interview take place in the hospital either before or after work, or during a meal break.

Recruitment of women's partners

Ethical permission to hold formal interviews with women's partners was not originally sought. It became apparent shortly after beginning to collect data from women, however, that it was essential to obtain their partners' perspectives. This was because much of women's own expectations and experience was engendered in response to their partners' childbirth values and beliefs. Also, women's partners expressed a very keen interest in sharing their experience and having it documented. Therefore, an amendment to the original ethics submission was submitted to both the hospital and Curtin University of Technology ethics committees, seeking permission to hold formal semi-structured interviews with women's partners. After permission to proceed was granted, women's partners were formally provided with information (see Appendix 1) about the study and invited to participate at the same time the women were approached at the PAC. For those partners who did not attend the PAC, the information was given to the women to pass on to their partners. Consent was obtained for those wishing to be involved (see Appendix 2), and was reaffirmed at each formal meeting.

Profile of participants

Twenty eight women participated in total. This number comprised 25 women who formed the main sample, and three who represented 'negative cases'¹. Twenty five women were recruited through the PAC, and three self-selected. One woman who was approached at the PAC declined to participate, stating that she had nothing to contribute because she was happy about needing to have a caesarean section;

¹ 'Negative cases' are participants outside of the main sample whose experiences provide examples that are "...counter to the emerging propositions...and can be used to refine them" Pope, C., S. Zieblanc, et al. (2000). "Qualitative research in health care: Analysing qualitative data." British Medical Journal **320**: 114-116..

however she contacted me later in her pregnancy and asked if she could change her mind, because she now “felt different about it”. One other woman declined to participate at the request of her partner, who did not want anyone else involved in their experience. Two other women who consented to participate went into labour and had non-elective caesarean sections before data collection took place, so were withdrawn from the study. Of the three ‘negative cases’, one self-selected and the other two were recruited through the PAC in the same way the main sample was.

Permission to attend their caesarean sections was requested from 17 women, 16 of whom agreed. The woman who declined did so on the basis that she and her partner anticipated that the operating theatre would be overcrowded as it was, and they did not wish to have an additional person present.

The participants were between 23 and 41 years of age, and had between no children and four children already (the average was one previous child). For those employed, their income ranged from \$A13700 to \$A122000 per annum, and educational achievement ranged between not finishing high school to having a masters degree. Seven women were employed in service positions, 10 were employed in management or professional occupations, seven were stay-at-home mothers, and one was a full-time student. Three women classed themselves as unemployed and in receipt of a government pension; one of those was studying part-time.

The women were from diverse cultural and socio-economic backgrounds: twenty-four were partnered, with two of those in a long-term same-sex relationship. Fifteen of the women were non-Indigenous Australian, one was Australian Aboriginal, and the remainder were migrants (four from the United Kingdom, two from India, two from New Zealand, one from China, one from Japan, and two from Vietnam). For the eight non-UK migrants, English was their second language.

Of the 28 women who participated in the study, 24 were partnered. Twenty-one of these partners participated. Of the three partners who did not participate, two could not speak conversational English. The remaining one, who was a fly in-fly out² remote area mine worker, indicated a wish to take part but was unable to; only brief telephone contact at the mine site was possible, and he was only due back in town

² ‘Fly in – fly out’ workers are those who are flown to their place of work and remain there for a continuous period – typically two or three weeks – and then return home again for a similar period.

late in the evening before his partner's caesarean section was scheduled.

Twenty-two maternity healthcare professionals also participated in the study. This number comprised eight midwives, four theatre nurses, seven doctors and three anaesthetic technicians. The group had been working with maternity clientele undergoing scheduled caesarean section for between two and 23 years, with an average of 11.5 years. A summary of pertinent information about each woman and health professional who participated is provided in Appendix 3.

Data collection

As previously stated, five forms of data were collected for this investigation; semi-structured interviews with women and with their partners (each held at two time points), non-participant observations of the operating theatre during participant women's caesarean sections, semi-structured interviews with healthcare professionals involved in caring for this group of women, and field notes. Interviews with women and their partners were held separately. A total of 242 hours and five minutes of data were collected. These comprised 101 hours and 44 minutes of interview data from women, 52 hours and 38 minutes of interview data from women's partners, 17 hours and 35 minutes of interview data from maternity health care professionals, 28 hours and 13 minutes of non-participant observation data from the operating theatre and other clinical environments, and 41 hours and 55 minutes of field notes.

Antenatal interviews with women

Antenatal interviews were held at between four and 48 hours prior to women having their caesarean section, the average time point being 18 hours. I had originally anticipated that each interview would last approximately 60 minutes, however most took significantly longer than this, the average being one hour and 49 minutes. Antenatal interviews were structured to encourage women to work backwards temporally through their original expectations for this pregnancy, to their childhood impressions, recollections and expectations of childbirth. I began by asking women to tell me how they were currently feeling about their caesarean section. I then went on to ask about how they had felt when they found out about the need for a caesarean section. I explored what their original hopes for their baby's birth had been, and whether and how these had changed. I also asked questions about their childbirth

beliefs, about whether the need for a caesarean section had challenged these beliefs, and about how women's partner, family, friends and acquaintances had responded to the news that a caesarean section had become necessary.

Semi-structuring the interviews in this way enabled me to clearly locate the women's thoughts and feelings about their impending caesarean section within the context of their personal world values and social context. Although the major interview themes remained consistent throughout, additional topics for exploration were included after data analysis revealed them to be of likely importance to the emerging theory. The complete original women's antenatal interview guide is provided in Appendix 4.

Non-participant observation of clinical environments

In using the techniques associated with non-participant observation (Gold 1958), I endeavoured to produce a rich description (Polit and Beck 2006) of the clinical environments that women were exposed to. These included antenatal clinics, pre-admission clinics, wards and the operating theatre department. I also followed a number of women through the hospital on the day of their caesarean section, from their arrival at 06.30hrs to the last 'stop' of the day – the postnatal ward.

Observations were recorded of how women behaved and interacted in these environments, and of how personnel interacted with women, their partners and each other. In antenatal care environments, data were collected in the form of narrative notes. In the operating theatre, however, observations were recorded at five-minute intervals by writing in pencil on a computer-generated pre-designed proforma (see Appendix 5). The form incorporated a diagram of the operating theatre and its fixed and mobile landmarks (for example, telephones, doors, the operating table, the anaesthetic trolley, the computer, the instrument trolley, waste bins, wall-attached worktops, mobile buckets, intravenous infusion poles etc). Beneath the diagram were printed a number of lines on which to write notes. The reverse of the form was blank, and this was used for recording further notes and reflections, as well as for making illustrative pencil sketches of poignant or seemingly pertinent scenes during the observation session.

I planned to record non-participant observations in the operating theatre during women's caesarean sections until no new information could be gleaned and saturation was reached. The procedure was carried out similarly on the first 12

occasions I attended. During the thirteenth however, I noticed subtle positive changes in practices, focus and communication patterns. I wondered whether these changes were related to my presence in the operating theatre having a consciousness-raising effect on staff. It was confirmed in interview with the operating theatre nurse educator that staff had indeed begun talking and behaving differently in relation to scheduled caesarean section than previously.

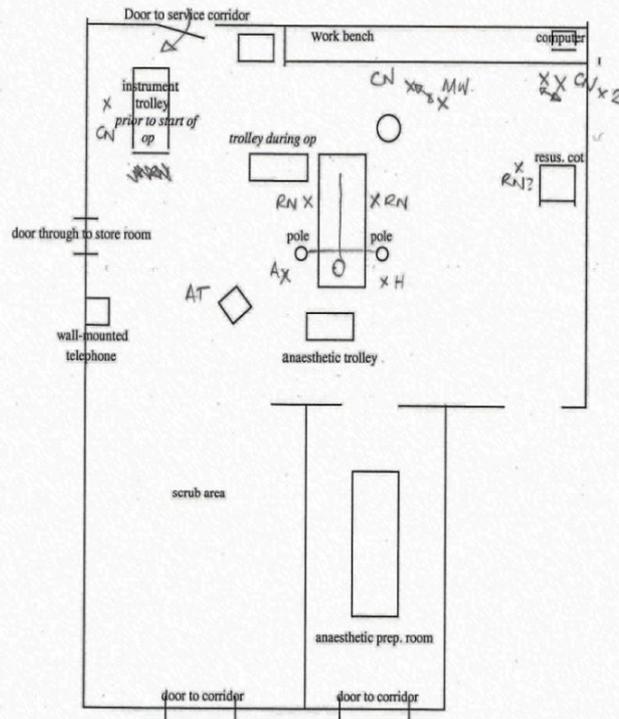
The fourteenth time I observed the event, the procedure was conducted somewhat unusually. The woman had arranged to scrub and wear sterile gloves in order to participate in retrieving her own baby through the surgical incision, in what became known as a 'maternal-assisted caesarean section'. This had the effect of provoking intense intra-professional debate about the nature and purpose of caesarean section. At the fifteenth and sixteenth caesarean sections I attended, it was evident that both my presence in the operating theatre and the occurrence of the maternal-assisted caesarean section had provoked the staff to consider their own intra-operative conduct. The operating theatre atmosphere, interaction patterns and work practices were noticeably different during these two caesarean sections, and they were conducted quite differently. In short, they were much more positive, joyful, lively occasions than the first 13 had been. After discussion with my supervisors, I made the decision to stop recording non-participant observations of the operating theatre despite not having reached full saturation, on the basis that I had become too familiar to the staff, and my presence as well as other influences was affecting how they behaved.

An example of a raw completed non-participant observation record is provided in Figure 5, and an example of a pencil sketch made in operating theatre during a caesarean section is provided in Figure 6.

Interactions in theatre during caesarean section

study ID number: 14

Date: 19.4.07 Time 10.30



- 10.32 - H brought in + seated
- Drapes it up - x 2 RNs catheterising pt.
 - Scrub nurse enters through back door with trolley
 - Music LOUD + 'BIP BIP BIP' - pulse oximeter?
 - TANNON - "Orderly to ... ?"
 - A chatting to H.
 - AT running a drip through.
 - Pt - 'I feel sick' - no response from anyone.
 - Several people in + out of A. room.
- 10.37 - Voice from beyond drapes 'Catheter's just going in now'
- A tells woman she might feel nauseous - loudly, because BP's dropped a little. She says 'Yeah, I did'
 - Woman blinking, eyes wide, ? IS she crying? She looks terrified.
 - Door opens (main door) A man in Theatre gear walks in, past woman, down to midwife + starts laughing + chatting.
 - Door again. 'BIP, BIP, BIP, BEEEEEEP, BIP, BIP BIP BIP BIP'

Figure 5. Record made during non-participant observation of caesarean section in the operating theatre.



Figure 6. Pencil sketch made during non-participant observation of caesarean section in the operating theatre.

Postnatal interviews with women

The second semi-structured interview with each participant woman was held approximately 12 weeks after birth. After consent to participate was again affirmed, I followed a similar retrospective format as I had during the antenatal interviews, beginning with a question about how the woman was presently feeling. I then went on to ask women to describe how they felt when they reflected on their caesarean section, and then to describe the experience of the caesarean section itself. I asked women about whether the experience had been as they had imagined it would be, and if so (or if not), in what way?

For the women whose caesarean sections I had been present at, I was able to ask them about certain aspects of their experience that I had recorded non-participant observations about, as well as their overall experience. The notes I made during each woman's caesarean section also served as prompts in some instances. I closed each postnatal interview at the point where we had begun in the antenatal interview, by asking how women were feeling as they anticipated their imminent caesarean section. Prior to visiting with each participant for the second interview, I reviewed the transcript of the first, noting specific issues that may be used as prompting questions. As with antenatal interviews, topics that emerged from ongoing data analysis that pertained to the emerging theory were also added to postnatal interviews. The complete original women's postnatal interview guide is provided in Appendix 4.

Interviews with maternity healthcare professionals

Semi-structured digitally-recorded interviews with health care professionals were undertaken at a time and place convenient to them. All interviews with health care professionals were held within the hospital setting. I had estimated that each interview would last between 30 and 60 minutes, which they did without exception, the average being 39 minutes. These interviews were all comprised of open-ended questions, for example "What, if anything, do you enjoy about working with women having a scheduled caesarean section?", "What, if anything, don't you enjoy about working with them?", "How do you imagine women and their support people feel about having / needing to have / having had a caesarean section?", and "Describe how you care for a woman who's having / who needs / who has needed a scheduled caesarean section". As analysis of other data progressed, I subsequently added in

other questions related to the emerging theoretical categories, and on several occasions, with their prior permission, I returned to staff members I had previously interviewed to ask more specific questions. The original health care professional interview schedule is included in Appendix 4.

Interviews with women's partners

Consenting partners were spoken with both antenatally and postnatally, and interviews followed a similar temporally retrospective format to that followed with women. Of the 21 eligible partners, 18 indicated a willingness to participate as soon as they were asked. The additional three who did not agree immediately contacted me at a later date wishing to arrange a time to talk. As with the health care professional sample, partners' semi-structured digitally-recorded interviews were arranged to take place at a time and place convenient to them. Seven were conducted in their own homes, seven were conducted over the telephone, and seven were conducted at the hospital. The interviews lasted between 25 and 75 minutes, with an average length of 51 minutes. Conversational questions asked of women's partners were similar to those asked of the women themselves, and were similarly temporally ordered. As for women and health care professionals, additional questions were added to interviews held subsequent to data analysis, which explored the revelations of that analysis. The original interview schedule for use with women's partners is provided in Appendix 4.

Field notes

The process of reflection that began with pre-data collection bracketing (discussed below) continued through the data collection process, in the form of observations, perceptions, thoughts and feelings which were documented before and after each interview, and before and after each non-participant observation period (Streubert Speziale and Carpenter 2003). My field notes therefore featured my impressions of the antenatal clinic and operating theatre environments, observations and thoughts arising during participant recruitment, and thoughts raised during formal interviews. They provided annotated records of informal conversations with midwives, operating theatre staff, women and their families, relevant exchanges with my own friends, acquaintances and family members, and news and other journalistic items of interest. An example of a field note entry made as a midwife addressed eight women and four partners who had attended the weekly 'pre-admission' clinic is provided in Figure 7.

13.40hrs Midwife talking loudly about what to pack, when to arrive etc... manner upbeat, authoritative. Talk is mostly dos and don'ts, occasionally illustrated by examples from her own experience. I can hear quiet sniffing / sobbing. Midwife continues. I hear a woman whisper "are you alright?" No reply, but the crying is openly louder now. The midwife stops what she's saying and asks "Is everything ok?" The crying woman responds by saying she's sorry, she only found out today that she needs a caesarean, she's still a bit upset and shocked. Can hear murmurs of sympathy. Few moments of silence. Midwife continues with giving info. My thoughts - 1) lot of abstract info given – do women 'get it'?; 2) info presented tells women what will happen to them + how to fit into the hospital schedule – not personalised at all, spoken to as if it's an operation they're having, baby spoken of as a wound would be, or a broken leg ; 3) it's quite some demand for woman to be expected to come to terms with it so quickly; 4) feel sorry for the midwife - imagine if it was me I would feel somewhat compromised? frustrated? by having to carry on / not being able to attend to and soothe woman; 5) other women/partners – might make them feel awkward / helpless / uncomfortable?? All in all, I can't imagine it's a very satisfying experience for anyone. I wonder what everyone involved thinks of it / feels after it?

> Ask women / partners / midwives / anaesthetists about PAC experience

Figure 7. Pre-admission clinic field note of 17th April 2007.

'Bracketing' prior to data collection

Prior to commencing data collection, I attempted to identify as many of my pre-conceived assumptions as possible. As both Crotty (1996) and Schutz (1994) identify, total objectivity in research is not possible, however according to Ahern there is an onus on the qualitative researcher to "make sincere efforts to put aside their values" (1999, p.407). In Phenomenology, the practice is known as bracketing, and is explained as a way of clearing one's view by recognising one's beliefs, perceptions and assumptions about a phenomenon, and putting them aside (Sokolowski 2000). Although 'view-clearing' is not specified as necessary in formal terms by Glaser (1978), he does state that the researcher should "enter the research setting with as few predetermined ideas as possible", and goes on to assert that by doing so, "the analyst is able to remain sensitive to the data...without first having them filtered through and squared with pre-existing...biases" (Glaser 1978, pp.2-3).

During the process of bracketing, I tried to deeply explore and acknowledge all that I thought, felt and assumed about how it would be to anticipate and experience a caesarean section about which there was no choice. I considered these thoughts, feelings and assumptions from the perspectives of each of my various selves - a

fertile woman, a mother, a partner, a friend, an extended family member, a consumer, a midwife, a nurse and a colleague. For example, having identified and bracketed as a fertile woman that I thought I would have a confused and mixed reaction to the news that I needed a caesarean section, and as a midwife that I 'knew' caesarean sections were risky and not to be decided on lightly, my 'consumer' self imagined I might feel resentful towards or dismissive of women portrayed in the popular press as having chosen caesarean section seemingly glibly, for lifestyle convenience and self-image reasons.

As an extended family member I bracketed that I could imagine, in the context of both my grandmothers, my mother, my sister, my aunts, my cousins and my sister-in-law all having had normal vaginal births, that I would feel different, and perhaps somewhat inadequate or a failure in my own and in their eyes. From my 'friend' self perspective though, I presumed I would find empathy, and feel somewhat more normal and accepted, within my circle of friends as many of them have in fact had a caesarean section; I imagined that if I were anticipating (or had experienced) a caesarean section that I had no choice about, that I would likely try and ally myself with friends who also were anticipating, who valued, or who'd had a similar birth experience.

Ahern suggests that bracketing should begin even before the research question is refined (1999), however I did not become aware of the need for this exercise until afterwards. Regardless, I found my experience of bracketing to be profoundly freeing. The process of deep introspection truly, I feel, enabled me to put my assumptions aside. I felt I would be much more able to listen to and appreciate women's own unique experiences from an objective position, without trying to process my own responses to them at the same time. Although I certainly agree with Glaser and Strauss' assertion that the researcher "does not approach reality as a tabula rasa" ('blank slate') (1967, p.3), the process of identifying and setting aside my own thoughts and feelings most definitely cleared my view.

Data handling and management

All interview data were digitally recorded onto an iRiver™ H10 digital voice recorder, uploaded to a personal computer, played through Windows Media Player™ and transcribed verbatim into Microsoft Office Word™ documents. I transcribed all

interview data personally. Non-participant observational data were scanned into a personal computer, and stored in a Microsoft Office Documents™ folder. Hand-written field note data was also personally transcribed into Microsoft Office Word™ documents.

All data was stored in accordance with the National Health and Medical Research Council's guidelines (National Health & Medical Research Council 2007). Computer files created within the Microsoft Office™ system ('Word'™ and 'Excel'™) were used to contain personal details, raw data and transcribed data. Entry to each computer file was protected with a password known only to myself. Written materials identifying participants (consent forms) were stored and located separately to de-identified raw data (demographic information, printed transcriptions of recorded interviews, and written observations and field notes). I am the only person to have access to the files. Also in accordance with National Health and Medical Research Council requirements (National Health & Medical Research Council 2007), all raw data is securely stored in locked filing cabinets at the hospital, and will be for a period of at least five years. No information identifying participants has been or will be used in written reports, presentations or publications.

Data analysis and theory generation

Data obtained for this study were analysed in two different ways. The analysis of data obtained from the semi-structured interviews held with women adhered to the principles, underlying logic and procedures originally set down by Glaser and Strauss (1967) and later expounded by Glaser (1978), while the remainder of the data were analysed using techniques associated with thematic analysis. Qualitative data storage and analysis computer software programmes (such as 'NVIVO™') are available, and while I did trial one such software programme, I found that I was not able to maintain an overall view of the data, concepts, categories and memos by managing the information in this way. I felt much closer to the analysis after I made a decision to manually code, categorise, memo and theorise using only the Microsoft Word™ computer programme. Handling the data in this way enabled me to see my analytical steps at a glance (in more than one document at a time if necessary). The cut/copy/paste functions facilitated constant comparison by allowing me to move conceptualised data and analytical segments around until I discovered their best fit.

Analysis of women's interview data

As previously discussed, data obtained for a Glaserian Grounded Theory study is processed through a four-stage cycling process. The four stages through which conversational data from women participants cycled were pervaded by three key Grounded Theory concepts: coding, memoing and constant comparison.

Coding has been identified as the primary intervention into the data in Grounded Theory studies (Walker and Myrick 2006). Glaserian Grounded Theory (1978) requires the researcher to engage in two types of coding. The first is termed substantive coding (comprising open and selective coding), during which any and all empirical data obtained is analysed and conceptualised. The second type of Glaserian coding is theoretical coding, and is concerned with the discovery of the relationship between the abstracted concepts.

Throughout coding and analysis, the researcher is obliged to document their ideas about the data, category formation and the emerging theoretical development in what are termed 'memos' (Polit and Beck 2006). Memos form the analyst's fund or storehouse of ideas, and after they are sorted and grouped, they provide the explanation of the theory, and form the basis of the research report (Glaser 1978). The necessity and importance of memoing is reinforced throughout the original Grounded Theory text, and subsequently through those of both Glaser and Strauss (Glaser and Strauss 1967; Glaser 1978; Stern 1980; Strauss and Corbin 1998; Streubert Speziale and Carpenter 2003; Glaser and Holton 2004). Constant comparison has already been discussed earlier on.

Stage one coding

Following purposive sampling and initial data collection, open coding is the analyst's first intervention into the transcribed raw data. The analyst is required to consider every line, sentence or incident and to code each "into as many categories as possible" (Glaser and Strauss 1967, p.57). Within 24 hours of recording the first semi-structured antenatal interview with a woman participant, I transcribed it into the left-hand side of a two-column table. I then ascribed a code to each meaningful statement and recorded it, alongside the source data, in the right hand column. This first interview was 76 minutes long, which was transcribed in to 13 A4 pages of double spaced text. First level analysis of this transcription eventuated in 144

different codes. An example of my first level coding is provided in Figure 8.

Transcribed interview	First level codes
<p>S: How are you feeling about the caesarean at the moment Yvonne?</p>	
<p>Y: Um...I'm.....I....I'm feeling better about the caesarean now) because I <u>have</u> to be...sort of, I've come to terms with the fact that it...it's going to happen...um, so what I'm <u>trying</u> to do is focus on the fact that I'm having the baby, and not focus on the surgery itself. Whereas...before that...or, I couldn't actually...it...having to have a caesarean took my joy away if that makes any sense, because I was just looking forward to having the birth that I wanted, just having that experience (of a normal birth)...ummm....but....ahm, having a caesarean, because I'm not one that would <u>opt</u> to obviously have a caesarean by choice, I couldn't get past the fact that I was being cut open. Because it just horrifies me. So now I'm just really trying to focus on the baby, so I'm a little bit calmer about it (laughs)</p>	<p>feel better no choice come to terms with it</p> <p>focusing on the baby trying not to think about the surgery</p> <p>needing a caesarean took my joy away</p> <p>wanted the birth I wanted wanted normal birth experience</p> <p>wouldn't opt for caesarean</p> <p>stuck on being cut open</p> <p>surgery horrifying focusing on the baby calmer now</p>
<p>S: And, um... have you been able to talk to the staff about all this?</p>	
<p>Y: No. No the staff didn't ask how I felt about having a caesarean, but they've been lovely, the staff were really lovely, but...a bit...I would say there's been a fair bit of just going through the motions if I'm honest. Even a bit... well they're not really focused on me as such, more on the surgery. No. It's all become a bit clinical now, a bit routine, very much they tell me what will happen now rather than a two way interview like before.</p>	<p>not asked by staff how I felt about it</p> <p>staff were lovely</p> <p>staff just went through the motions</p> <p>staff focused on surgery not me all a bit clinical now all a bit routine told what will happen no two way interview now</p>

Figure 8. Example of first level coding.

The process was followed with the second interview, and then the activity of constant comparison began. Codes from the first and second interviews were compared, and

alike codes were grouped together. In this way, categories are formed and given tentative names. Following the first-level coding of subsequent interviews, as well as continuing to compare them with one another and develop new categories, I also compared codes against previously identified categories to see if, how and where they fit. While open-coding and categorising the data, I bore in mind Glaser's suggestion to continually 'ask' what the main problem of these women was. Staying close to the data and not assuming personal characteristics of participants were of any theoretical relevance unless they emerged from the analysis as such were also considerations (Glaser 1978, pp.59-60; Glaser and Holton 2004, p.13).

At the same time as identifying codes and developing categories, I also wrote memos about how I perceived the data was suggesting women anticipated and experienced a caesarean section unexpectedly scheduled for health reasons. These memos form a progressive record of my thoughts and ideas about how the categories were linked. As already discussed, Glaser asserts that memoing is fundamental to Grounded Theory (Glaser 1978), and is the activity that marks it as different from other qualitative data analysis methods (Glaser and Holton 2004). Examples of my memos are provided in Figures 9-11.

20/3/07. 11.18am. open coding 06/11.

Saying she's not planning, or expecting anything ^{hoping for}
but then lists ^{detailed} plans, hopes + expectations!

Says she's not stressing but she's not sleeping = she's having nightmares, + has made arrangements if she dies.
Same day Jan is being taken over by terror*

Figure 9. Memo – example 1

Trying to GRASP what this woman experienced:
 she wasn't forgotten as such, she wasn't even
 acknowledged in the first place. Wasn't on
 the radar for most people.

Dr = spoke with her → forgot her → spoke with her
 again

everyone else: didn't even seem to see her ~~person-~~
~~ness~~. Only her abdomen. (wound).

Disappearing off the radar?

Disappearing from view?

Figure 10. Memo – example 2

reading something about MPP as
 a reason for CS and it says 'the
 placenta blocks the baby's path to
 freedom). It occurs to me that
 'NO WAY OUT' describes this to me
 and then that this is a double
 entendre: it has meaning and
 relevance for the BABY and the
 WOMAN - there's no way out of a CS if there's
 no way out for the baby.

Figure 11. Memo – example 3

The process of open coding, categorisation and memoing continued until a 'core problem' and a 'basic social process' were identified which were both relevant and worked (Glaser 1978). The core problem is explained by Glaser as the category "which appears to account for most of the variation around the problem or concern

that is the focus of the study” (Glaser and Holton 2004, p.15). Strauss and Corbin identify it as representing “the main theme of the research” and as a condensation into a few words of “what this research is all about” (Strauss and Corbin 1998, p.146). According to Glaser, the definitive criteria for the core problem are that it is central, it relates to as many other categories and their properties as possible, and it accounts for a large proportion of behavioural variation. It must also be clear, have ‘grab’, relevance, and explanatory power (Glaser and Holton 2004, p.15). The core problem for women facing and having an unwanted and unexpected scheduled caesarean section emerged after 14 antenatal interviews and 6 postnatal interviews, and was identified as **Being Made Redundant**.

According to Glaser, basic social processes (BSPs) may also be evident in the data (1992). The BSP is characterised by the fact that it is illustrative of a social process that continues over time regardless of varying conditions, and has “...*two or more clear emergent stages*” [original italics] (Glaser 1978). While Glaser dictates that it is always possible to find a core problem, this is not so for a basic social process. Like all else in Glaserian Grounded Theory, basic social processes must emerge from the data. To go looking for a process, states Glaser, is to ‘force’ the data (1978; 1992). Glaser identified two types of BSP, those being the basic social psychological process (**BSPP**), and the basic social structural process (**BSSP**). A **BSPP** is a process that occurs for individuals and groups, while a **BSSP** refers to changes in social structural arrangements (Backman and Kyngäs 1999). In the study reported here, a BSP did emerge, and as it suggested itself as a psychosocial process, was deemed to be a **BSPP**. In this study, the BSPP emerged after 11 antenatal interviews and eight postnatal interviews, and was labelled **Regrouping**.

Together, the core problem and the BSPP comprise the Grounded Theory that explains how women experience and process an unexpected, unwanted scheduled caesarean section. In this study, because the problem and process only fully unfolded over a period of time, the Grounded Theory was labelled **Becoming Redundant**.

Data that represented the “conditions and consequences and so forth that relate to the core process” (Glaser 1978, p.61) were also categorised. Four factors emerged that moderated women’s response to their experience. These moderating factors, which limited the strength of women’s reactions (Issel 2008), were labelled as **Expecting**

and wanting birth to be natural, Hurling towards ‘D-day’, The green drape and Caesarean is hospital not women’s business.

Stage two coding

Once all categories were reasonably saturated and the core category, BSPP and moderating factors had been identified, open coding of all new data ceased and theoretical, or selective, sampling and coding ensued. From this point on, I only sought and coded data which related to the core variable and the BSPP (Glaser 1978; Glaser and Holton 2004), and to the moderating factors.

My decision to ‘shadow’ some participants through the whole day of their caesarean section, from their arrival at 06.30am to their final stop on a postnatal ward later the same day, is an example of this. At that time, the core category of **Being Made Redundant** had been established and consisted of a number of sub-categories with ‘working’ labels such as ‘Feeling no more than a case on an operating list’, ‘Just an abdomen’ and ‘Unseen’. The data and theoretical memos for these sub-categories were at that point only about women’s antenatal experience, and I was keen to know whether their perceived ‘invisibility’ continued on and beyond the day women actually had their baby. Following women through the day of their caesarean section enabled me to uncover more about this aspect of women’s experience.

Stage three coding

Theoretical coding was then undertaken. The categories that were formed from the codified data during open and selective coding were configured to demonstrate how the categories and their properties interconnected, were linked and were related to each other. The aim of this stage was the integration of all relevant categories and concepts identified during the previous coding phases. The resultant comprehensive pattern forms the Grounded Theory. To assist researchers with this aspect of the process, Glaser offered a set of linking patterns by which aspects of the theory might be related. These linking patterns are known as coding families. These include, for example, the “Six C’s” coding family, wherein each category might represent a context, a condition, a co-variance, a cause, a consequence or a contingency, the “Process” coding family, the categories of which might each represent a stage, a phase, a transition or a step in a sequence, chain or trajectory, and the “Strategy” coding family, in which all categories are a dimension, element, part or aspect of a

whole (Glaser 1978). The theoretical coding families are interpreted by Fielding and Lee (, p.38) as a means for providing “conceptual connections between different categories, and between categories and their properties”. Schreiber and Stern (2001, p.132) describe Glaser’s coding families as a “shopping list of theoretical codes...to aid the analyst in thinking about relationships among the categories”. Alternatively, Titscher and associates (Titscher, Meyer et al. 2000, p.78) interpret coding families as a means by which “theoretical concepts are dimensionalized”.

Importantly, Glaserian Grounded Theory requires that the theoretical family to which categories belong must, like everything else in this methodological version, be suggested by the data itself. Strauss and Corbin’s method, on the other hand, prescribes that researchers code their data against a predetermined coding family. Glaser identified and described 18+ coding families, however he warns the analyst that they are not mutually exclusive and are likely to overlap. He also intends that researchers who seek to link their categories in this way devise their own coding family, or system (Glaser 1978).

Heeding Schreiber and Stern’s (2001) warning that pre-selection of a coding family may encourage the analyst into performing content analysis rather than Grounded Theory analysis, stage one and two data grouping and categorisation in the study reported in this thesis was undertaken without specific coding families in mind. Only after these stages were completed did it become apparent that the categories of the core problem, the basic social psychological process and the moderating factors belonged to a family. The nature of their family, suggested by the categories, emerged to be a temporally-ordered cyclic pattern that incorporated three of the ‘Six C’s’, namely causes, consequences and conditions.

Parsimony, or the pursuit of simplest explanation of the phenomena using as few constructs and propositions as necessary, with no “excess baggage” (Leong and Austin 2005, pp.457, 458), was also pursued at this stage. This occurred through the removal of irrelevant categorical properties, the integration of elaborating details and the integration of categories. This systematic reduction of categories into fewer higher level concepts in Grounded Theory is called “one-upping” (Glaser 1978, p.59), and is demonstrated in the example provided in Figure 12. This example shows how the exercise resulted in the development of one of the major categories of

the basic social psychological process, labelled as **Striving to be included whilst trying to behave**.

Smaller closely-related 'working' data groupings...	...'one-upped' into	...one encompassing 'final' category
Concentrating on keeping the staff happy Spontaneously reaching out for my baby Desperately attempting to get someone's attention Trying hard to keep my emotions in check		Striving to be included whilst trying to behave

Figure 12. Example of categorical 'one-upping'

Stage four coding

This stage is characterised by sorting, both of the parsimonious concepts into their final order, and of the memo stockpile into the explanatory 'story' of the concepts. The aim is to reach a "reasonably accurate statement of the matters studied...couched in a form that others going into the same field could use" (Glaser and Strauss 1967, p.113). The final order of the concepts that contribute to the Grounded Theory of **Becoming Redundant** is provided in Figure 13. The detailed 'story' of how the concepts relate to one another is presented at the beginning of Chapter 4.

In Glaser and Strauss' original view, to be judged as useful a Grounded Theory must exhibit "four highly inter-related properties" (1967, p.237). Perhaps most importantly, the theory must fit with both the social reality of the participants' situation and the understanding of it by others who are familiar with the social setting. It should also be understandable to laypersons as well as professionals. For the theory to be useful, "generalisability" is also necessary as this facilitates application of the theory "to multi-conditional ever-changing daily situations". Finally, the theory must lend itself to ongoing modifiability "when it does not work in application"; it must enable users of the theory to adjust it either to better suit their situations, or as conditions change (1967, p.237).

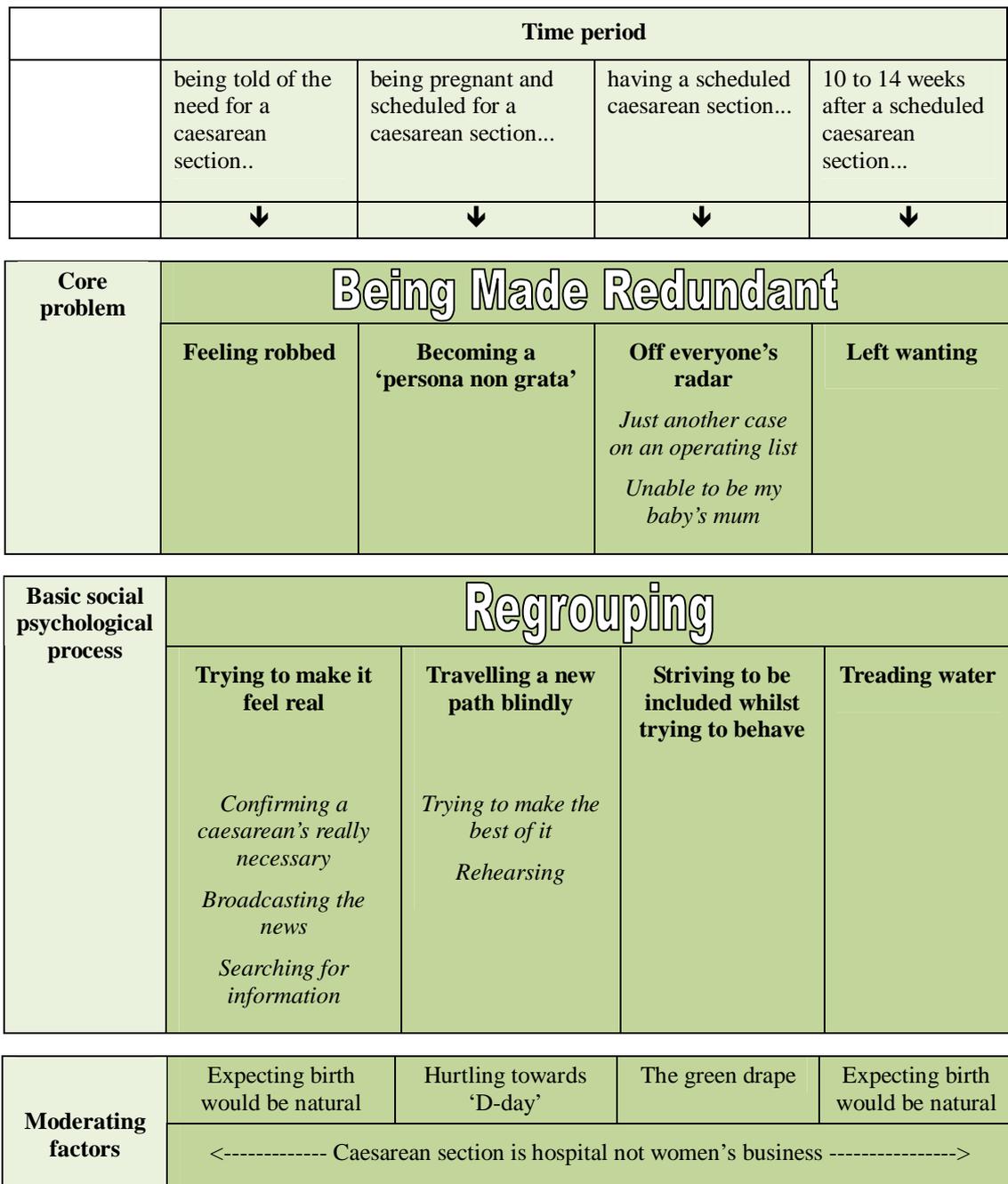


Figure 13. Final order of theoretical concepts: 'Becoming Redundant'

Analysis of remaining data

As the purpose of collecting information from other human participants, from non-participant observation of the operating theatre during caesarean section and from field notes was to contextualise the women's experience, these data were analysed thematically using the 'editing' style. Derived from the Latin *edere* – 'to give forth', the editing style is a form of qualitative analysis that helps to bring forth greater understanding of, or meaning from, text or data (Addison 1999).

Interviews with women's partners and health care professionals were analysed similarly to those of participant women. Interviews were transcribed verbatim, within 24 hours of recording, into the left-hand side of a two-column table. I then read through the raw data in search of meaningful segments that bore some relation to the women's conversational data, and ascribed a code to each one. These ascribed codes were recorded alongside the source data, in the right hand column. The coded segments were then categorised, and the structural links that connected the thematic categories were then identified (Polit and Beck 2006).

Field notes and non-participant observational data were not formally analysed, in that no conclusions were drawn from them as a whole data subset. Rather, I translated them into conversational prompting questions. For example, my observations of the frequency and nature of sudden environmental noise occurrence prompted me to ask questions in postnatal interviews about how women and their partners recalled the noise in theatre, and whether and how it affected their experience. These same observations also prompted me to ask health care professionals about their awareness of environmental noise in theatre, and about their perceptions of whether and how it might impact on patients' experiences. These data were juxtaposed with the women's data to either confirm or contextualise their experience, and served to add depth and richness to the findings.

On several occasions during postnatal interviews, women and partners (without exception) struggled to recall the details of their time in the operating theatre, and many became frustrated and saddened by this inability to recall some of the moments leading up to and after their baby's birth. On every occasion, it was very helpful to be able to prompt their recollection with the five-minutely observations and the pencil sketches I had made. These also appeared to be very comforting to the participants, and almost all asked if they may have copies of the observational data sheets and sketches to keep as mementos of their experience.

Trustworthiness

Trustworthiness in qualitative research involves determining the degree to which researchers' claims about knowledge correspond to the reality (or participants' constructions of reality) being studied (Eisner and Peshkin 1990). Researchers need to demonstrate that their studies are credible (Golafshani 2003). Similar to Glaser

and Strauss (1967), Lincoln and Guba suggest that four criteria can be utilised to assess trustworthiness in Naturalistic inquiry. These include credibility, transferability, dependability and confirmability (1985, p.219). Other criteria by which the worth of a qualitative investigation is evaluated are how vividly and faithfully the phenomenon is represented, and the degree to which the findings can be traced as trustworthy (Beck 1993; Carpenter Rinaldi 1995). Cho and Trent assert that these qualities might be assessed in terms of either transactional or transformational trustworthiness (2006).

The transactional approach to validating qualitative research involves interaction between the researcher and the research participants, by the use of such measures as member-checking and triangulation. In member-checking, findings are presented back to informants to check for perceived accuracy (Cho and Trent 2006). Triangulation, or the use of multiple sources (Denzin 1989), provides a means of deriving a more consistent, objective picture of reality than would a single source (Cho and Trent 2006). Triangulation may be attained by drawing on different types of data and / or multiple investigators' interpretations of the data (Golafshani 2003). Transformational validity, however, is determined by the resultant actions prompted by the research endeavour (Cho and Trent 2006).

Trustworthiness in this study was pursued through both transactional and transformational approaches. Data were triangulated by the collection of not only women's own interview data, but by observational data, and interview data from health care professionals and women's partners. Investigator triangulation was sought through informal and formal discussion and debate around the emerging concepts, categories and theory with my supervisors as they arose. Recognition and accuracy of the emerging theoretical rendition was also provided on a number of occasions both from women who had had this experience, and from health professionals who cared for this group of women.

I arranged, on two occasions, to present the data to women who were members of the community group 'Birthrites: Healing After Caesarean'³. Both sessions were well attended by a total of 26 women, in whom the study findings evoked deeply

³ 'Birthrites: Healing After Caesarean Inc' is a not for profit community group run by and for women who have had, are having or want to know more about caesarean section. The group also provides support and resources to women wanting to pursue vaginal birth after caesarean section (VBAC).

emotional responses, confirmed their own experiences, and stemmed a very animated discussion on each occasion. In response to the data, participants in these two sessions repeatedly said, for example, “that is exactly what it’s like”, “that is just how it feels” and “that’s what happened to me”. Throughout the analysis of this data, the emerging findings were also presented at a number of professional study days and conferences, including a National midwifery conference and an International midwifery congress (Bayes, Fenwick et al. 2007; Bayes and Dufton 2008; Bayes, Fenwick et al. 2008; Bayes, Dufton et al. 2009). Audiences at each included maternity care consumers, doctors and midwives, among whom the findings evoked strong emotional responses. Some women cried, and many came to speak with me at length afterwards to tell me the themes were strongly reminiscent of their experience. The work also seemed to resonate with health professionals’ experience of caring for this group of women; an example of this occurred at one conference, when an obstetrician stood, spoke of the findings as “truly eye-opening”, and initiated a standing ovation. Such reactions to this work provide clear confirmation that the findings do vividly and faithfully represent the phenomenon.

Further affirmation of the trustworthiness of these findings is demonstrated by the maintenance of records pertaining to theoretical decision-making and development. Wolf (2003) suggests that an audit trail, or “confirmability” audit might include, for example, evidence of the “details of data analysis and some of the decisions that led to the findings” (Wolf 2003). One such piece of evidence is provided in Figure 14.

My documentation of each stage of the investigation through the use of memos has provided a historical path that diagrams the analysis of data, links between different categories and their properties, my reasoning and rationale for decisions made, and justification of conclusions drawn (Streubert Speziale and Carpenter 2003). In transformational terms, both the location of the study in the clinical areas of the hospital and the study findings engendered a number of clinical practice changes. These are described in depth in the last chapter of this thesis.

Ethical considerations

The study was designed and conducted in accordance with the Australian National Health and Medical Research Council’s National Statement on Ethical Conduct in Human Research (NHMRC 2007) and the World Medical Association’s Declaration

Raw data >	Open codes >	Sub-category >	Major category >	Core category
<p>“was <u>lumped in with everyone else</u>, like, you’re <u>just a number</u>“</p> <p>“came up to me and said, “<u>the breech</u>, yes?””</p> <p>“and <u>not once did anyone use my name</u>”</p> <p>“overheard a conversation about <u>the third case</u> and realised they were talking about me”</p> <p>“by the end of the day I thought my name was <u>‘last on the list’</u>”</p> <p>“felt like I was <u>on a bit of a production line</u>”</p>	<p>lumped together just a number the breech</p> <p>never referred to by name</p> <p>the third case</p> <p>last on the list</p> <p>production line</p>	<p>Just another case on an operating list</p>		
<p>“my whole body switched into <u>‘prepare to hold baby any moment’ mode</u>, and she <u>just never appeared!</u> For aaaaages”</p> <p>“and <u>they kept him</u> for yonks”</p> <p>“they <u>took her down the end</u> and I <u>couldn’t see her</u>”</p> <p>“and I could hear my baby crying, poor little thing and...I just <u>wanted to be his mummy</u>, you know, but <u>he was too far away</u>”</p> <p>“<u>I just wanted to do my job and comfort him</u>, but I <u>couldn’t</u>”</p>	<p>prepared to hold baby baby never appeared</p> <p>staff kept baby</p> <p>baby taken away couldn’t see baby</p> <p>wanted to be mummy baby too far away</p> <p>wanted to do my job wanted to comfort him but couldn’t</p>	<p>Unable to be my baby’s mum</p>	<p>Off everyone’s radar</p>	<p>Being Made Redundant</p>

Figure 14. Development of major category of core problem – ‘off the radar’

of Helsinki (WMA 2000). Permission to conduct the investigation was sought from and granted by both the Human Research Ethics Committees at Curtin University of Technology and The hospital for Women.

On first being approached, all potential participants were provided with a plain English information sheet (see Appendix 1) detailing the nature and purpose of the study and the use and handling of information. Assurance of confidentiality by, for example, the de-identification of raw data and the use of a number-coding system,

was included. Potential participants were provided with contact details for me, my supervisors, and the chairpersons of both the University and the hospital Human Research Ethics Committees should they wish to ask further questions or raise problems. Women, staff and partners who agreed to participate were asked to sign a consent form, within which they would be apprised both of the voluntary nature of their participation and of their right to withdraw from the study at any time without penalty. Consent forms are provided in Appendix 2.

It was anticipated that participant women and/or partners may have questioned the decision for caesarean section and other care issues while participating in the study. I discussed and agreed with my supervisors that, should this occur, I would respond within the limits of my knowledge and experience and within the bounds of nursing and midwifery professional conduct, and if necessary, would refer the individual or couple back to their responsible obstetric medical team for further discussion. I also arranged with the hospital's Department of Psychological Medicine that, in the event that issues should arise during interview which evoked upset and distress in participants, they would provide follow-up support. If care through the hospital was declined, I had an agreement with 'Mental Health Direct' – a 24 hour mental health telephone triage and referral facility – that I would encourage distressed participants to access their service, and advise them to seek urgent attention from their own or an out-of-hours GP.

In fact none of the participants or their partners questioned me about the decision for the caesarean section, or became unduly anguished during interview. One participant, having recognised that considering and discussing her feelings about her impending caesarean section evoked unpleasant memories from her previous birth experience, did decide to seek independent counselling in an attempt to integrate and move on from that birth experience and 'connect' with her current pregnancy. Finally, the time, date and location of all interviews were arranged for the participants' own convenience and comfort.

Summary

This chapter has presented how the Glaserian version of the Grounded Theory methodology was selected for a study of 28 Australian women's experience of giving birth via a caesarean section scheduled for health reasons. The background and

origins of Grounded Theory were described as a qualitative methodology within the naturalist interpretivist scientific paradigm. The original version of, background to and variations of the Grounded Theory methodology were then outlined. My rationale for taking a Glaserian Grounded Theory approach to the investigation reported followed, and the bracketing exercise I undertook before data collection commenced was described. The way the methodology was utilised to conduct a study of women's birth experience was then detailed. Sampling, data collection, data analysis and theory generation have all been explained. The ways in which trustworthiness was pursued have also been provided, as have the ethical considerations of the investigation. Women's core problem, the basic psychosocial process, the factors that moderated women's experience and three negative cases that confirm the theory will now be described over the next three chapters.

Chapter 4

‘Needing and Awaiting’ Caesarean Section

So anyway that’s all been taken. How I wanted it to go is not possible now. That dream’s been snuffed out...

Anne, 37 weeks pregnant

You’ve heard stories of people getting on a plane having planned for months to go somewhere, but the plane crashes in the jungle or something? Well I know how they feel! There are no signposts, you’ve got no guidebook, there’s a native tribe looking at you from afar but they’re giving nothing away (laughs)...It is like I’ve landed in a completely foreign country, night has fallen, and I’ve just got to find my way out somehow.

Kylie, 36 weeks + 5 days pregnant.

Introduction

The next three chapters present the findings of this study. In this chapter, the reader is provided with an overview of the categories and their relationship to each other; the categories that explain women’s experience of the time period between hearing of the need for a scheduled caesarean section and the last days of pregnancy will then be reported in depth. The data that is relevant to the day of the caesarean section and beyond is then shared in the next chapter (Chapter 5), before the factors that moderated women’s experience are presented in Chapter 6. Throughout the text, all category and sub-category labels are presented in sentence format (first word capitalised) and in **bold** type. Where the core problem and the basic social psychological process labels are used, they are also presented in bold type, and each word is capitalised.

Overview of the findings

Data analysis revealed that prior to the emergence of a need for caesarean section, women had a clear perception of their childbearing role, purpose and identity.

Commonly, they talked of having a job to do, of knowing what that job was, of believing and accepting it was theirs to execute, and of wanting to do it. In a context of absolute personal conviction that natural birth was unquestionably best for their baby's and their own well-being, the women identified themselves as being responsible for birthing their baby, and as ready and happy to be so. When the need for caesarean section arose, though, the data suggest that women were presented with the problem of being entirely relieved of their job and of responsibility for their baby's birth. Data related to the problem women faced was classified into four emergent categories, labelled **Feeling robbed**, **Becoming a 'persona non grata'**, **Off everyone's radar** and **Left wanting**. Each of these sub-categories related to each other, and contributed to a core category labelled **Being Made Redundant**.

What was also evident in the data was that all of the women set about trying to adjust to their perceived loss of role, and commenced working to make the best of their new situation. These efforts were noted to continue well into the postnatal period. A basic social psychological process (BSPP) undertaken by the women also emerged from the analysis. Because women's redundancy happened incrementally and subtly but rapidly, their response to it was simply about trying to keep up with and make sense of what was happening to them. Labelled **Regrouping**, this BSPP comprised four stages. These were labelled **Trying to make it feel real**, **Travelling a new path blindly**, **Striving to be included but trying to behave** and **Treading water**.

A number of factors that hampered women's ability to accommodate and manage their new reality were also found in the data sets. An additional four categories emerged from the data to explain why women experienced and processed their caesarean section in the way they did. Three of these categories represented factors that each moderated a particular aspect of women's experience – these were labelled as **Expecting birth would be natural**, **Hurtling towards 'D-day'** and **The green drape**. The fourth represented a factor that moderated the whole of women's experience, which was labelled **Caesarean section is hospital not women's business**.

Although women effectively became redundant from the moment they became in need of a caesarean section, the real extent of the problem only became apparent through the remainder of their childbearing experience. As their redundancy became

more extensive and more compounded over time, so women invoked new psychosocial responses to it. Women's ability to fully address each aspect of the problem that emerged was severely moderated by a number of factors. This meant that they continued to try and process what had happened to them well into the postnatal period.

In the next part of this Chapter, the first two categories of the core problem, labelled **Feeling robbed** and **Becoming a 'persona non grata'**, are reported. This is followed by the description of the related first and second stages of the basic psychosocial process, labelled **Trying to make it feel real** and **Travelling a new path blindly**.

Feeling robbed

Immediately women were told they would need a caesarean section, they described it being just like they had been assaulted or robbed. Women reported feeling greatly destabilised on hearing the news, and having immediate and intense physical reactions to it. For example, women variously described feeling "unbalanced", "giddy", "spun out" and "out of whack" for some hours after they left the hospital that day. For Rose, hearing the news left her feeling "pretty wobbly", Fiona was "totally knocked sideways", Cherry was "completely floored" and Madeleine described feeling "as if a rug had been pulled out from under me". Jan just couldn't believe it: "I just thought...what? (shakes head) WHAT? It was a complete...an absolute total spin out". Yvonne, whose baby engaged in the breech position, said

Well...I did know she wasn't head down but it just didn't occur to me that it was a problem! Then it slowly dawned on me, with what they were saying, that it was. Once I realised, I tried everything to get her to turn but she just stayed there. Natural things – acupuncture, getting round on my hands and knees.. Then I came in and I had the ECV⁴ and that didn't work... and basically that was that. When they said the words that I was going to need the operation...oh... [shakes head]. My mouth went dry. I felt sick. I thought I was going to collapse. That was it, basically. I wasn't having her normally anymore.

Yvonne went on to describe how "gutted" she was when she realised her fate, and talked of feeling her "insides fall into my boots". Similarly, Madeleine, who had a

⁴ An 'ECV' is an external cephalic version. This procedure, which is carried out by a doctor skilled in the manoeuvre, is an attempt to externally move a fetus who is presenting by the breech (bottom) around into a 'head down' position.

placenta praevia, said “as soon as the ultrasound woman told me the placenta hadn’t moved up and almost certain I’d need a caesar [sic], oh my stomach just dropped”. Donna, whose baby lay in a persistent transverse position at term said, “when they told me I would need a caesarean section it really hit me hard. It felt like I’d been slapped”. Adrienne said that not only was the news physically unsettling, it was also humiliating. She said,

I just felt totally stupid for being so naive. It never occurred to me that I’d have anything but a normal, simple, straightforward birth. I just came away thinking “Whoa!” (stands up, pretends to stagger backwards, waves hands above head). Egg on face or what?

Adjectives normally associated with appropriation of precious goods or cherished personal effects were also common in the data, as women spoke of their imagined birth being coldly and callously “seized” or “stolen” by the need for caesarean section. Rose said her anticipated natural birth was “just snatched off me. In the blink of an eye”.

In the absence of anyone to hold accountable for their new situation, women personified the caesarean section itself as “it” - the perpetrator of their lost security. Jeanne, for example, said “it’s just a thief”. Steph said “it’s took [sic] my birth off me”. These women expressed that the caesarean section also relieved them of the ‘special-ness’ of having a baby, as demonstrated by phrases such as “it took my joy away” (Dee) and “all the magic’s taken out of it” (Kylie). For Tamsin, “all the good feelings (she) had about it went”. Rose analogised the effect of the news about needing a caesarean section as “like some stranger just walked up, looked me in the eye, popped (her) balloon, and walked away again without, you know, a backward glance.”

Six of the women, having been profiled as ‘low risk’ when they had originally booked at the hospital, had chosen midwives-only care for their pregnancy and birth. For them, an emergent health condition that necessitated a caesarean section meant this was no longer appropriate, and they were moved into the care of an obstetric team. All talked at length about having ‘their’ midwives taken off them. Jan, for example, spoke extensively about having developed a “trusting, mutually respectful, meaningful relationship” with “her” midwives, but that, “to add insult to injury that was taken off me as well.” Many of the women’s partners also talked of how being

“forcibly removed”, as Aaron put it, from their chosen model of care negatively affected women. Dave, for example, described it as “pretty devastating” for his wife to have to “meet new people with a very different view of things at that late stage”. The partners themselves also described having felt well supported by the midwifery model of care and reported, as Theo said, having “realised what we were missing” when they subsequently found themselves unacknowledged and excluded. Lee’s experience of accompanying his partner to antenatal visits in the main clinic for example was “as if I was invisible or I didn’t matter. Not once was I acknowledged or spoken to”. Many of the other partners interviewed reported this experience similarly. Midwives working in this model of care, too, reported feeling sad to ‘lose’ women and concerned for their wellbeing. Midwife Jane, for example, reflected the sentiments of others when she commented on it being,

a real shame when you can’t see women through, when you’ve built a nice trusting relationship. Women become special to you and you really feel for them when they have to go over [to another model of care], well I do anyway. And of course you know they’ll be fine but you do think, mmm... but she’d be finer [sic] if she had someone she knows looking after her.

Women also held the need for a caesarean section responsible for robbing them of their confidence, as they described how the news engendered feelings of fear, and of being “haunted” (Karen) that had not been there previously. Women talked of living with terror as a constant companion since the decision. Fleur, for example, commented that the news “frightened the life out of (her)” and said, “I literally felt like something had me round the neck”. Kate, like others, spoke about her impending birth “having a shadow over it now”. Most of the women voiced that it was the thought of having an operation that terrified and preoccupied them, and could be no more specific than that.

A few women, though, were able to determine exactly what was frightening them, and identified two specific problems. One was related to having had their autonomy usurped and being left with no control over the situation or their bodies. Karen, for example, described “just hating the thought of being totally helpless, totally vulnerable”, and Tamsin said she thought it was “the whole ‘not being in the driving seat’ thing that [she was] just dreading”. Similarly, for Cherry it was “the thought of being completely in their hands, at their mercy”. To Anne, a nurse who was familiar

with surgery, the thought of “being dependent...being strapped down” was “horrifying”. For Keira, “not being in control of (her) body frighten(ed) (her)”.

The other basis for many women dreading a caesarean section was that it might mean poor bonding with the baby. Kate, for instance, was “worried [she] just won’t feel anything special” and went on to explain that she meant she was “frightened [she] won’t feel anything for the baby, won’t connect with it”. Tina’s fear was that she “we won’t get off to a good start, you know, me and the bub” and similar to Kate, clarified that she meant “in terms of, like, bonding, just having the time and space to meet each other”. Jo summed up this particular fear in a similar way to other women when she said,

There’s that constant message, isn’t there, “you’ve got to bond, you’ve must bond”, or you’re in for all sorts of trouble down the line, and I’m really, really worried, that I just won’t be able to bond with it. Because of the fact of having a Caesar that I don’t want, I’m worried about feeling like, “whatever”, about the baby. And I imagine it as busy, busy, rush, rush, and all that gets forgotten. And then it won’t know I’m its mother or something, I don’t know.

Two women, Madeleine and Tina, feared the caesarean section to such an extent that they imagined the certain outcome to be catastrophic. Tina was a 33 year old healthy woman carrying a normal healthy baby, her second child. Her baby’s breech position persisted despite attempted external cephalic version, and at 37 weeks pregnant she consented to a scheduled caesarean section to be performed at 39 weeks pregnant. When I first talked with Tina seven days prior to her caesarean section, she spoke of her conviction that she “might not make it” through the surgery. She also spoke of making preparations for that eventuality, such as making a will and mobilising her extended family to help her husband care for their children. Figure 15 provides an excerpt from the transcript of our interview:

Tina	I’m all organised, now, anyway. I’m as ready as I can be [shrugs shoulders. Looks at floor].
Me	What do you mean by organised? Organised how?
Tina	Well in the last week I’ve been to the bank and the solicitor, I’ve done a will. Made sure all my papers, pension stuff and that, are all in one place where <my husband> can. you know, lay his hands on them. I’ve arranged for my family to help <my husband> look after <the children> if I don’t make it. [Begins to cry] Umm...what else? [Looks

	up to the ceiling]. Yeah. I've told <my husband> that if he has to choose between us, to choose for the baby, not me... [begins crying, unable to speak further].
--	---

>> one minute 32 seconds break in interview until Tina recovers >>

Me	Are you ok to continue Tina? [Sitting close, holding her hands]
Tina	Yes...yeah. No, I want to. Sorry. I just...<my husband> and me talked about it and it was very, very hard but we've...it's fine now. I don't mean...I mean it's not fine, but we kind of...it's ok.
Me	OK. [Long pause] Tina, sorry...I just want to get this right so I need to ask...Are you saying that you think you could die in there?
Tina	[Nodding] Mmm. Yeah. Well people die in routine surgery every day don't they? I might. Why not me? I could die in there. I just wanted to be prepared, and now I am prepared.

Figure 15. Excerpt from transcript of interview with Tina

This disclosure of Tina's that she thought she may well die during her baby's birth, and her obvious distress at the thought, were deeply moving to me, and it took some effort to maintain my focus during the interview. My reflections on her disclosure, which I noted in my field notes are provided in Figure 16 below.

<p>I thought at first, when Tina said she was organised, that she meant she'd bought all the baby gear, arranged for someone to look after (her son) on the day, packed her bag etc. I never for one minute imagined she meant she'd arranged things for if she <u>dies</u> in there. I didn't think I heard her right at first. I had to stop for a few moments when she said it. And so calmly! As if she <u>really</u> thinks she might <u>die</u>, and worse, that she's got to a point where that's ok! She accepts it as a possibility. We don't know women <u>feel</u> like this! We have no idea. And we treat them – it - so flippantly.</p>

Figure 16. Field note: researcher reflections on Tina's 'fear of dying' disclosure

While Madeleine didn't envisage dying during her caesarean section, she did foresee a very frightening series of events unfolding when she imagined the procedure. She was expecting her first baby, and had conceived through in-vitro fertilisation. When I first chatted with Madeleine, she was 36 weeks pregnant and a hospital inpatient, as she had been diagnosed with major placenta praevia. A caesarean section was scheduled for when she was 38 weeks pregnant. As we talked, Madeleine told of her fears around her impending surgery, which included haemorrhaging, hysterectomy,

and becoming infertile:

When they told me I had to have it (the caesarean), all I could see in my head was just all red. I don't know how to describe it. Like with my eyes closed, the inside of my head was all red, I don't know if that makes sense? I've dreamed about having a haemorrhage and blood everywhere....I'm aware of the very real possibility that I could bleed in surgery. And then that led on to me thinking "then they'll have to do a hysterectomy" and having no more children, and who would look after and love the embryos that are left, and to me and the baby being in special care, and not being with and bonding with each other, him not getting my milk, and I'd need a general (anaesthetic) so then I thought of my poor husband being really frantic with worry outside the theatre....And him having to tell all the relatives (relatives), and having no support... You have to stop yourself or you'd go mad. You have to try and think, "But you've got no choice, so stop worrying". But you can't stop worrying. It's horrible.

During my interviews with maternity healthcare professionals (MHPs), including midwives, nurses, doctors, and anaesthetic technicians, I asked how they imagined it to be for women to hear they needed a caesarean section, and what impact they imagined such news might have. Across the professional groups, MHPs empathised strongly with the sense of abrupt deflation and bewilderment that eventuated in most women's data. Approximately half of the MHPs imagined it would be, for example, "terrible", "so disappointing", "probably a bit of a shock", "gut-wrenching", "no doubt incredibly distressing for some", "a let-down" and "very confronting". On the other hand, equally as many either underplayed or simply did not recognise the impact on women, suggesting it to be "no big deal", "nothing to get upset about", or "probably a relief". These MHPs were unable to recognise that women would be anything other than thankful, and ostensibly wondered "what's the issue?" Interestingly, many of the MHPs whose first response was empathetic then tempered, or countered their initial response with such comments as, for example, "but at the end of the day, you'd just have to accept it and move on," (Midwife Jo), "whatever, though...they'd have to realise it's about what's best for the baby." (Nurse Michelle), or "if that's that, well that's that. It is, it's too bad but I guess...there's no point crying about it." (Dr. David).

Becoming a 'persona non grata'

Category two of the core problem explains how, almost from the moment their caesarean section was scheduled for them, women began to feel displaced or exiled

by the procedure. In essence, women perceived that its needs came to take precedence over theirs. The procedure itself seemingly came to be the first problem of the personnel women encountered. Women noticed, for example, that the focus of the hospital staff's problem noticeably shifted away from the woman herself and onto the paperwork and tests involved in getting ready for the procedure. This was women's experience even when there were a number of weeks to go. Women nostalgically conveyed how their prior antenatal care had included staff investing time, energy and enthusiasm into progressively preparing them for the day when they would have their baby, and how this changed abruptly after the decision for caesarean section was made. Karen, for example, described her experiences at the antenatal clinic before she was booked for a caesarean section:

Each time I went I talked a little bit more with the midwife about, you know, things to help me get ready for (giving birth), like...I don't know, erm...well, like...good positions, how to cope with it all, deal with the stress, stuff like that. And it was like, we'd do a bit more every time I went, all working up to the big day.

Trinny, too, talked about how, "at each appointment, (a midwife) would do the checks then we would carry on what we'd talked about last time. Yeah...building up to the big day I guess." Likewise, Tina felt her antenatal care had, up to the decision for a caesarean section being made, been "all aimed, yes, at making sure me and the bub was [sic] healthy for it, but as well, that I was all set, you know mentally, for doing the huge task of giving birth". Keira described how, at her antenatal appointments, "whoever (she) saw would share a little tip, this or that helpful little nugget of information...we always talked about something about giving birth", and went on to talk about how this made her feel. She said, "It was nice. It was like they were as interested...excited as me! They really seemed to be bothered that it went good [sic] for me. Yeah. It was lovely. I felt very positive, very confident." Sally, when asked to describe her antenatal care prior to the decision for a scheduled caesarean section, recalled that it had been

all smiley and, you know, (rubs hands together) "Oooh, not long now!", and about what more info they can cram into my brain so I do a half-decent job of it. Yeah. To the point where sometimes I've thought: "Whoa! Yes! All right! Calm down! Who's having this baby?!" Not really, I'm joking. It's been very cool. It's been very nice that (the midwives) have been so into it. It makes you feel like...well, yeah, special, I suppose.

After the booking for their caesarean section had been made though, things changed. In stark contrast to before, women described that although staff remained polite and pleasant, they became cooler, more distant, less interested in them personally, and solely focused on physiological measures and tasks to be completed in preparation for the operation. Donna said, “All of a sudden I, me the person, I’m kept at arm’s length”. Janine recalled, “They used to ask how I was, did I have any questions et cetera, and really seem to want to know. It’s not really like that now.” Tina’s experience of antenatal care after the decision was that,

the care became much more clinical. That was VERY noticeable. Everyone was still lovely, still polite... they still asked me how I was, but it definitely wasn’t the same. It was superficial. Like, there wasn’t that genuine interest there. You feel like you’ve become a bit of a nobody actually, or a nuisance. A bit of a burden. I don’t know...I mean it’s like, you’re there but you’re just there to be measured. Like, for them, not for me? It’s definitely like...they’re just going through the motions and I am just a, what do you call it? *Persona non grata*. Yeah, I’m not really welcome to be involved in my own care!

It was from this part of Tina’s data that the label for this sub-category was taken. Anne noticed that “problem for how I was feeling has become a thing of the past”, while Julia recalled that “appointments became very much more business-like”. For Cherry, “the talk became all, do this, do that, sign this, get this blood test done...(laughs, shakes head)”, which she said she “took to mean basically – we don’t care about you really as long as you turn up, do what needs to be done and don’t stuff up our procedures”. Janine felt similarly, recalling that

One day it was all lovely, let’s get you geared up for the amazing momentous job you’re going to do and then – nothing... it all stopped. Just like that. No more of that at all. It just became very, ahm, clinical I guess would be the word. Wee, weight, blood pressure, check the bub, “yep fine”, “sign that”, “get this test done”, “shut the door on your way out”, “next”.

Adrienne encapsulated many women’s sentiments when she described feeling

“like I could be having an ingrown toenail done, which yes, you would expect to be treated a bit like in, out, no need to get too involved. But, you know...we are having a baby! It is a huge thing for us. And I am definitely not treated like I’m doing anything miraculous.”

Women’s perceptions of the emphasis of care shifting to prioritise the caesarean section procedure were confirmed by my observational data. The following excerpt

from my field notes (Figure 17) provides an example of how clinicians focused more on the preparations for the caesarean section than on the woman herself during antenatal appointments.

Sat in on a number of appointments with permission from all involved today. Quite literally, individual appointments are just a form filling/ box-ticking exercise, crossing the t's, dotting the i's, making sure nothing's missed to cause a hiccup in the process. Very impersonal. Not that the staff weren't polite, kind, personable, welcoming, pleasant, they all were, but their focus was quite definitely on making sure the necessary information is given/obtained so that the procedure goes efficiently. And with that seems to come a bit of an air of indifference to the emotional side of having a baby, and to how women are going with that. There's been no talk actually about the fact they're having a baby! It's all been about the operation.

Figure 17. Field note: researcher reflection on focus of clinic appointments

Data from women's partners also reflect a sense of being "completely unseen" (Colin) or "unwelcome" (Elton) in the care environment, as many reported either not being voluntarily acknowledged, not being voluntarily spoken to, or not being voluntarily included in a meaningful way in discussions or decision-making about their partner's and baby's care by maternity health care professionals. George conveyed the mixed emotions reported by many of women's partners when he said, "I wanted to be there for her, but honestly, I might as well have been the chair I was sat [sic] on for all the notice they took of me."

As well as feeling as if they were no longer welcome to participate in their own care, women also described sensing that their new identification as someone scheduled for a caesarean section shifted them into a less deserving "underclass", as Janine termed it. This became evident to them as they were deprived of certain services they had previously been afforded. When they had been anticipating giving birth naturally, most women had, for example, been planning or had begun to attend antenatal classes in preparation for labour, birth and early parenting. Going to such classes, they said, was not just about getting information. It also promised or provided a source of support and inclusion, in that it represented an opportunity for women and their partners to share their birth hopes, worries, questions and experiences with other pregnant women and their partners.

As such, many women talked about attendance at antenatal classes as something they

expected and wanted to do as part of being pregnant. As Steph said, “It’s just what you do. You want to do it, don’t you? It’s part of the whole having a baby, being in a special ‘club’, thing”. When the need for caesarean section arose, though, many women told me they were advised by midwives there was no point attending antenatal classes any more. Women were commonly told, like Dee, “if you’re having a caesarean, there’s no point coming anymore”. This was very upsetting for many, and left women feeling they had been somewhat discarded, as evidenced by their use of such terms as “banned” (Fiona), “barred” (Trinny), “dumped” (Rose) and “given the flick” (Jeanne) from attending.

As well as being provided with antenatal preparation classes, women anticipating a natural birth were also invited to tour the labour and birth suite. The purpose of the tour was to enable women and their partners to become familiar with the environment they would be having their baby in. Women having a caesarean section, though, had no need to go to labour and birth suite and so were not invited to tour the hospital; in a number of instances, in fact, they reported being actively uninvited. In interview, many lamented the fact that some women had the opportunity to familiarise themselves with the area where they’d give birth, while they didn’t. Women also apportioned some of their fear about having a caesarean section to not really knowing how it would feel to be in the operating theatre environment, and they variously described imagining it as, for example, “stark”, “brightly lit”, “tense”, “charged”, and “cold”. Rose represented the sentiments of many when she said,

When you think about it, it is a terrifying prospect. Tied down. Lights shone in your eyes. Masked strangers standing over you with knives. Surrounded by machinery. You can see where I’m going, can’t you? (laughs > becomes serious). And I mean it might not be like that at all, but what I’m saying is I’ve got no way of knowing. At least if you’re having it natural [sic] you get to see where you’re going, ask questions, get a feel for it...

A number of women’s partners described feeling similarly, and expressed a degree of anxiety about going into an unfamiliar environment. Rob, for example, said he would have “been able to relax about it a bit if I could picture it in my mind”. To John, the lack of opportunity to visit the operating room prior to the day of the caesarean section represented yet another of several disempowering care omissions that collectively, he personally identified as measures designed “just to make sure you really get that you’re not important at all, and that you’re not in control of any of it”.

John identified these ‘omissions’ as not being acknowledged by or included in interviews with caregivers, not being able to stay overnight with his wife after she had her caesarean section, and being unable to continue with the model of care of their choice.

Women also felt as if they lost out on something by being booked for a caesarean section because no process existed for them to document or communicate their hope/s for their baby’s birth. In interview, all women mentioned at least one specific wish for their caesarean section that they hoped would happen. These wishes were largely related to behaviours that they hoped would help them bond with their baby, and help make their caesarean section a memorable, even sacred, experience. Such wishes included, wanting to discover the baby’s sex for themselves, being the first person to speak to the baby, and being able to hold their baby skin-to-skin as soon as he or she was born.

While women felt strongly about having these things happen, they were frustrated and anxious about not being able to document their wishes anywhere. At the time this study was conducted, the only birth plan framework provided to pregnant women was for a natural birth. Consequently Donna, like others, wondered, “So where do I write down what I want my baby’s birth to go like?” Madeleine was worried that “I’ve said to people a couple of times if I want to find out myself what sex it is, breastfeed it and that but there’s nowhere to say it, and no-one I’ve told has made a note. So actually, who makes sure that all happens?”

Feelings associated with being considered a ‘persona non grata’ were often heightened and reinforced by the reaction of other people towards their need for a caesarean section. All women cited instances of being treated as ‘lesser’ than women having a natural birth by some of their friends, family, acquaintances, strangers, and even by some of the maternity health professionals whose care they were in. The following quote from my interview with Sally characterises women’s realisation that being someone who was having a caesarean section diminished their worth in others’ eyes:

One day, I was at the servo of all places, and it clicked. The woman behind the counter said something derogatory about caesars and I thought “ohhhh...ok. (nodding slowly). I get it”. It took a few different things like that, but, ‘til it dawned on me that having a caesar does equal being a bit

of a ditz in many peoples' view.

Women also told of instances where they had been either “dismissed” as “weak”, “selfish” or “stupid”, regarded as “pitiful”, or made to feel like “a disappointment”, or “less of a woman” by others. These inferences came by way of comments or behaviours of partners, friends, family members, complete strangers and hospital staff members. Jo, for example, whose (female) partner Kate’s immediate reaction to the news of a caesarean section was relief, perceived a change in her response in the hours after the decision. Jo went on to say,

So, yeah, she seemed really relieved at first, like, for her I guess, but... then when we got home from the hospital that day, with the date for the caesarean, instead of being excited, it was a good couple of hours before she said anything. She was very, ah, cool to me. And I know...I could see. She was a bit disappointed in me (shrugs). She was. I know she was.

Karen’s caesarean section was scheduled for just before Christmas, and while out doing some last minute seasonal shopping, she got chatting to a lady in a checkout queue who commented that the heavily pregnant Karen should be at home resting:

So I said “Oh, well I’m trying to do my Christmas shopping cos I’m having a baby on Friday,” and she said “Really? How d’you know you’re having it on Friday?” and I said, you know, “well I’m having a caesarean.” She just looked at me. She said, “Oh, right.” And she changed, she got a bit prickly. She gave me a bit of a look! Like, (raises eyebrows, looks up and down). As if...I dunno, she thought I was a bit...I don’t know what, stuck-up, dim...something anyway.

Fleur talked of feeling “pretty hurt” when her mother-in-law apparently jokingly told her friends that she was “one of those women that’s [sic] too posh to push now”. Janine similarly recalls a close friend “going on and on...generally just giving me a lot of stick for it”. Women were perhaps most unsettled, though, when they were vilified by healthcare professionals. Jan, for example, recalled feeling taken aback and belittled when she overheard two midwives discussing that the reason for the increasing caesarean section rate was that “women are basically stupid”. Despite it being clearly reported in Sally’s notes that she would be unable to birth her baby vaginally, she recalled being spoken to “quite condescendingly” by a midwife, who advised her that “if all these women, meaning me, had any idea what they were letting themselves in for they would never choose a Caesar!”. Sally went on to say “As if I’d just gone “Oh please, yes, please will you just cut me open for no good reason?” I so didn’t!” Sally said she was left feeling “like the scum of the earth”.

Trying to make it feel real

Once they had recovered their composure a little, women began trying to adjust to their new reality. ‘Trying to make it feel real’ is the first stage of the basic social psychological process. It comprised three sub-categories, each of which represents a strategy undertaken by women in their regrouping efforts. These provide the reader with some indication of just how much emotional work was involved for women in managing and adapting to their changed circumstance.

The first sub-category was labelled **Making sure a caesarean’s really necessary** and involved women trying to verify, in all sorts of ways, that the decision to schedule a caesarean section was truly justified. The second sub-category was labelled **Broadcasting the news**, and told of women’s deliberate decision to disclose their need for a caesarean section to others as a way of helping themselves to realise and integrate it. The third and final sub-category of ‘trying to make it feel real’ was labelled **Searching for information**, and was about women’s efforts to try and find out about what having a caesarean section would be like and how they could expect to feel during the procedure.

Making sure a caesarean’s really necessary

To begin to move forward from and work with the decision for a scheduled caesarean section, women described having to be convinced that there was no real option but to have one. They did so in a number of ways, for example by seeking second, third and fourth professional opinions both within and outside of the institution, requesting repeated diagnostic investigations and examinations, and seeking non-professional peer guidance and opinion from internet forums. For example on being told of the need for a caesarean section after an ultrasound scan showed her placenta was covering her cervix, Steph’s first response was to “ask for another scan a week later, before (she) signed on the dotted line.” Similarly, when Jan got home from the hospital appointment at which she was told she wouldn’t be able to have a natural birth, she

straight away phoned up the clinic again and made some excuse to get another appointment, with a different doctor. I just wanted to hear what someone else had to say about it, you know, tell me what they... I just wanted to be absolutely sure.

Karen, who I spoke with antenatally while she was a hospital in-patient, was

awaiting a caesarean section because her baby was not engaged (had not dropped into her pelvis towards the end of her pregnancy). She had been advised at 38 weeks of pregnancy that there was a risk of umbilical cord prolapsed, the consequence of which was that her baby could very quickly become oxygen-deprived, which in turn could lead to the baby becoming disabled or dying. After being given this information, and told that she likely wouldn't be able to give birth naturally, Karen said she left the hospital against medical advice. On reaching her home she telephoned two alternative maternity health care facilities for their opinion. Only after extensive discussion, during which similar advice was forthcoming, did she return to the hospital to consent to and wait for the caesarean section.

For some of the women in the study, their health condition meant that vaginal birth was not completely impossible but was highly inadvisable from a medical perspective. Several of the women in this situation described seeking opinions and advice from internet communities they had become part of, such as pregnancy chat rooms and question-and-answer forums. Women utilised such communities to see what other women thought, and to elicit what they felt would be unbiased views and common-sense opinions. Kylie, for example, whose caesarean section was advised because her baby was presenting by the breech and all measures to encourage the baby into a 'head down' position had been unsuccessful, said:

They (the hospital) gave it all to me what could go wrong with having it normally, and... well I was beside myself... when I went home I got onto <well-known internet forum>. I just wanted...I dunno, just... to work it through some more. So I asked for people's thoughts, any research they could give me...And I got replies saying "no, no...challenge it, you can do it, it'll be fine...". I got a lot of advice - get him to turn, do this, stand on your head, try that (laughs). But mainly, it was pointing to "No. Don't take the risk". And I suppose 'cos from everything I read it mainly seemed it wouldn't be as safe to have him normally, that was it. It made me feel like, ok. I'm happy now, it's not a load of crap what the doctors have told me, d'y'know what I mean? What the doctor said, other people have said... pretty well said the same as what (hospital staff) said, yeah. Like I didn't not believe the doctor but it's only one person's opinion and, you know...you don't know. But I definitely felt more like, "yeah, ok then" after I checked it out and chewed it over a bit more.

In all cases of women going onto internet forums and seeking additional professional opinions to try and weigh up whether a scheduled caesarean section really was necessary, the original advice they received was confirmed in their mind as 'right'.

There were no instances of women concluding that the information they had been given by the hospital was wrong, or that their scheduled caesarean section was unjustified after further exploration.

Broadcasting the news

Whilst confirming in their own minds that there was a genuine need for their caesarean section, women also begun to tell other people the news. To some degree, this seems to have been part of the previously-reported strategy of helping to gauge opinion about the necessity of the procedure. However, the data suggests that broadcasting the news was primarily about women trying to make it “sink in”, as Anne termed it. All of the women made some reference to the fact that telling another person or other people about the caesarean section helped them accept it was true and really happening. As Madeleine said, “I think sharing it with people, that’s what really brought it home to me”.

For women whose partners were not with them when they were advised of the need for a caesarean section, they were the first person they told when they got home. All waited to tell their partner in person rather than over the telephone, except one woman whose partner was away working and would not be home for another week. A number of women recalled they had been apprehensive and unsure about their partner’s reaction. Jan, for example, was “certain (her partner) was going to be disappointed because all he’s talked about is supporting me, racing through red lights to get there, rubbing my back this, birth that”. More often than not, though, women found their partner responded more favourably than they had expected: Madeleine’s husband, for instance, had been “incredibly stressed about the whole thought of seeing me in labour and giving birth, so for him, it made his day (laughs)”. Yvonne said her partner Ethan’s response was that “it was sort of, well, it’s regrettable, but overall his view was, well ok, if that’s what’s best for the baby well that’s that”. Dee said her husband Gerry “didn’t stop smiling for a week”, while Jo said her (female) partner’s reaction was relief, and that she “said something like “Oh thank God for that!” or words to that effect (laughs)”.

While data from some women’s partners supported this perception, in that a few reported having felt quite stressed about supporting women through labour and birth, and used phrases such as “relieved”, and “off the hook” to describe their initial

reactions to the need for a caesarean section, by far the majority of partners reacted with confusion to the news. Differently to the women themselves, who immediately, clearly and definitely knew how they felt about needing to have a caesarean section, their partners did not, and for them, broadcasting the news was most definitely about working out how they ought to respond themselves. Many partners' comments echoed Terry's experience. He said, "I was sort of on hold about it 'til I told my mates, and they were all really, aw, "you beauty!" They were like, happy and excited for us, so then I thought "yeah!" (big grin, thumbs up), it's all right". Terry went on to say that he "stopped worrying about what to think and I started looking forward to it then." Likewise, Jason said:

(Long sigh. Scratches head. Eyebrows raised). I didn't know what to think when she told me to be honest. Errr... (scratches chin, looks down)...She was pretty devastated but I didn't really feel like that. I dunno. I felt alright I suppose (shrugs shoulders)...everyone else, all my mates, family and that, they seemed to think it was all right, no biggie, yeah. So...yeah, kind of went with that I guess.

Women also felt some apprehension about telling the news to their wider family, although as when they had told their partners, most found them to react with empathy, compassion and encouragement. Those who did feel their loved ones were accepting of the fact used phrases such as "very supportive", "really understanding" and "totally OK" to describe their responses. Some families though, did not respond so favourably. Rose, for instance, said her family found it "very un-funny [sic]" and "grilled me big-time, is it really necessary, wanting me to get a second opinion. Aaaargh [shakes head]! Mum went on and on about it..."

Whether women's families were supportive or not, many women said that their partner's and families reactions were at odds with their own feelings about it. Julia, for example, said that her family were not only accepting, but that they were "almost smug about it". She said that her three sisters, who had all caesarean sections for a range of reasons, gave her the impression that they thought she was over-reacting. Julia said she felt that they "did not get – at all – why I wouldn't be pleased or relieved". Donna, who described herself as "devastated" by the news said her family "treated it as no big deal". Some families, like Anne's, seemed as if it was "pretty cheesed off. In fact they seemed quite put out by it. I don't know, they almost seemed to feel more pissed off and let down than I did".

Although telling their news did help the fact of their caesarean section ‘sink in’ for women, incongruity between their own and their loved ones’ responses left women feeling very alone, as they spoke of feeling like they had no-one to talk about it with, or not feeling welcome to bring it up in conversation. Dee, for example, said “there’s been no point talking about how I feel because [her husband] just does not get it. He’s rapt about it. Very happy. So it’s been quite lonely really”.

Telling people the news also unwittingly invited some well-meant but ultimately unhelpful advice, suggestions and opinions. These ranged from “throwaway comments” (Sally) to in-depth attempts at agitating women into considering pursuing a natural birth in any case. The effect of receiving such uninvited advice and opinion was “confusing” and “bewildering” to women and, it seems, some were ultimately “moved backwards” into a state of flux again. Among the more superficial but incendiary and tiresome comments fielded by women (who, by this point, already had a process underway to confirm that their caesarean section was absolutely necessary), were suggestions that they, for example, “try natural therapies to turn the baby”, “don’t listen to (medical staff)”, “do more research before deciding”, “not just give in”, “check the risks (of caesarean) before agreeing to it”, “look into it all a bit more before I go that road” and “don’t just take it at face value”. Kate, for instance, who had been planning a natural birth under the care of midwives, talked of how unsettled she felt by the response of a friend (who was also a midwife) to the news that she would now need a caesarean section for malpresentation. She said,

I think she meant well but she discredited the doctor’s opinion as wrong, and said probably if I’d seen another...a different doctor I would have still been able to have a natural birth. So then I was really confused again. I was back to wondering if it WAS really necessary. I was right back to square one again.

Dee was similarly unsettled by a close friend’s views. The reason given to her for having a caesarean section was that she had an abdominal myomectomy with a classical (vertical) incision which, in the opinion of the obstetrician she had consulted with, rendered labour and natural birth unsafe. When Dee told this as the reason she was booked for a caesarean section to her friend, she

totally poo-pooed it! She didn’t say as much but she rolled her eyes and looked at me as if to say, like “Yeah. Right”. I dunno, I thought it sounded safer for the Caesar [sic] the way (the doctor) explained it, but

then I felt as if I didn't really trust it after that. It made me wonder about if I did really need it.

Searching for information

Once the initial shock of the news that they would need a scheduled caesarean section had abated a little, women described quickly developing a voracious appetite for information pertaining to the procedure. As they regained a degree of equilibrium, all of the women began to seek out and access resources they thought would help them “get to know” caesarean section. Phrases such as “increasing my knowledge”, “making me feel more comfortable with it” and “taking away the unknown” were common to the data set. Like the other women, Kylie became “an information junkie” and said she had “a stockpile in my head of everything I've found out [about caesarean section]”. Seemingly, women's collective hope was that finding out about the procedure would simultaneously reduce their apprehension and help them feel more at ease with it. Women put significant time, effort and money into seeking out useful and relevant resources, and often went out of their way to do so. They talked of searching for information in many different places, of assuming the information they wanted would be out there, and of their frustration when their search proved fruitless. Most women, like Donna, began at the hospital. She said,

I just assumed if I asked the midwife for more info I would just be given something to read or a DVD or something and that would be that. But when I asked she said “No, don't have anything, try the hospital resource centre on the ground floor.” So I went there thinking “this is the place”. That was a no again, “But,” they said, “try the library across the corridor, they might have something.” Anyway, off I goes [sic], and nothing there either. You can imagine I was starting to get slightly frustrated by this point.

Having found no information at the hospital, the next port of call for most women was their local public library. Although three women did find some references to caesarean section, this search also ultimately proved futile. Dee said her local librarian found her “an ancient video of a caesarean” that “from the way it was presented it was for doctors or medical students”. Cherry said she “found one book on caesarean section on the (library) shelf” but that “it was all about how to avoid ending up with one (laughs)”, and was “very interesting, but absolutely useless”. Fleur, having searched the public library collections on the internet, recalled how “maddening” it had been to have travelled some distance to collect a library book

that sounded promising, only to find it was of “no use whatsoever”.

Many women reached the conclusion that if there was no information available at the hospital or the library, they would pay for it. Thus, their search took them to new and used bookshops, thrift stores, and to the magazine racks of newsagents and supermarkets. Adrienne, for instance, said she “didn’t care what it cost” because she was “getting desperate.” Steph said if she “could have found what (she) was looking for (she) would have happily bought it.” Tamsin stated she “bought every pregnancy magazine going in case there was something about caesars [sic] in there”, while Yvonne commented she “just about cleaned (an on-line book seller) out”.

Women said that the little information they did find on scheduled caesarean section almost exclusively described the procedure from a ‘cold’, objective viewpoint, and while this type of information was of some interest, women said it was inadequate. Many said that what they wanted was to know about scheduled caesarean section from a subjective, personal, experiential perspective. Their data reveals a collective strong yearning to know what having a caesarean section was going to feel like for them, in both sensory and emotional terms. This yearning is exemplified by many quotes in the data set, including “I want more, I want to know how I’m actually going to feel during it” (Janine), “what I want to know is how it’s going to affect me” (Kylie), and “it’s not enough to just know what’s going to be done, I want to get a feel for it (holds both hands up, makes grasping movements). You know, how do you *feel* [original emphasis] when it’s going on?” (Anne). This type of information, women said, simply did not seem to exist.

Frustrated and disappointed by the lack of available information about scheduled caesarean section, some women then moved to human resources to satisfy their need to know what to expect. They canvassed friends, colleagues, relatives and even arranged to speak with acquaintances that they knew had been through the experience, and asked them directly what it was like. As they had when confirming to themselves that their caesarean section was genuinely justified, some women also used the internet and online chat rooms or forums. Yet again, it seemed their endeavours were in vain, as women said their sources could either only describe the experience in vague rather than specific terms as they would have liked, or their stories served to heighten rather than abate women’s fears and problems. Julia, for

example, had two sisters whose babies had been born by scheduled caesarean section. They both told her to “just close (her) eyes” because “it would be over before (she) knew it”. Sally said her cousin’s advice was that there was “nothing to it”. Trinny said her next door neighbour “really couldn’t tell me anything; she said it just was a bit nothing-y”. Steph said “the lady across the road just said it was ok” and wondered “whatever that means I don’t really know.” What others had to say of their caesarean section experience was reported by women as not reassuring or comforting, as some friends and acquaintances they spoke with told of their feelings of fear, discomfort, vulnerability and powerlessness during the surgery, and of an extensive range of complications afterwards. As a consequence, women became less, rather than more, reassured about their impending caesarean as they had hoped they would be by finding out more.

Travelling a new path blindly

In response to having had their job appropriated by the need for a caesarean section, and to neither receiving or finding any guiding information about having one, women set about trying to ready themselves for the procedure the best they could. This second stage of the basic psychosocial process comprised two sub-categories, each representing a strategy employed by women to prepare for their caesarean section. The first sub-category was labelled **Trying to make the best of it**. It conveyed how women actively decided to downplay the disappointing and frightening aspects of a scheduled caesarean section, and chose instead to look for good things about the situation. In many cases, women revised their thinking on features of caesarean section they had originally considered negative, and turned them into positives. This included switching their attention and preparations *away* from the experience of giving birth and *onto* the moments around meeting their baby and becoming his or her mother. The second sub-category was labelled **Rehearsing**, and was about the attempts women made to envisage how the caesarean section might go, how they might behave during the procedure, and what their role might be within it.

Trying to make the best of it

As a way of making their caesarean section less scary and more manageable, women consciously chose to downplay its magnitude. Fiona and Adrienne said they had decided to think of it as “just a procedure” and “just an operation” respectively.

Madeleine said she chose to regard it as “simply something to get through”, while Kate condensed it to “only a few minutes”, and declared it “probably nothing to get worked up about”. My field notes on these parts of interviews, however, reveal a degree of mismatch between women’s words and their behaviours. Figure 18, an excerpt from the field notes I wrote following my antenatal interview with Julia six days before her scheduled caesarean section date, provides an example:

...words coming out were saying “it’s no big deal, what’s to worry about, it’s just an everyday routine operation” but she became very tense as she said it - shuffled in seat, sat bolt upright, interlocked fingers, began rubbing her thumbs rhythmically up and down over each other. She seemed as if she was trying to convince herself but that she didn’t really believe it.

Figure 18. Field note: researcher reflection on behavioural dissonance (Julia)

As well as minimising the perceived enormity of a scheduled caesarean section, all women also consciously tried to put a positive ‘spin’ on birthing in this way. The cited perceived benefits that appeared in the data included knowing exactly when the baby would arrive, feeling it would be less stressful for partners, having a longer postnatal stay in hospital, having the baby in the daytime so visitors could be accommodated, not going through labour, not having any labour pain, and knowing the procedure would be calm and controlled. Interestingly, many of these contrived advantages are also reasons women cited for *not* wanting a caesarean section earlier in interview (these are described in more detail in Chapter 6). When women talked of the benefits of having a caesarean section, it was in an intellectualised, factual, business-like way, whereas when they had spoken of giving birth naturally, their language had been very soft, body-focused and emotive.

Tamsin, for example, who had originally been planning and hoping for a natural birth in a midwife-led birth centre, and who had talked extensively about valuing and respecting “the mysteries and unknowns of birth”, identified the benefits of having a scheduled caesarean section as follows,

So, the positives for us why it’s a good thing are (holds up right hand)...number one (makes a fist and sticks thumb out) no labour, so no pain. Number two (touches thumb and forefinger together) it’s in the day so everyone, the staff, won’t be exhausted, so it’ll be calm, controlled, cruise-y. Number three (touches thumb and first two fingers together) [my husband] won’t have to do labour so he won’t be stressed. Number four (holds four fingers up) we know when it’s happening so we can sort

of do a countdown and get excited. Mmm. Yeah. So, what I've done, I've tried to think of ways it to make the best of it.

At the same time as trying to put a positive spin on the need for a scheduled caesarean section, women were also switching their focus away from the process of giving birth and onto meeting the baby. Women used a variety of terms to describe surrendering their idealised birth. Many spoke, for example of "letting it go". Others, like Yvonne, said they had put the birth itself to the back of their mind. Tamsin talked about having "made a mental shift away from me". Instead, women chose to put the moment they would meet their baby into the space evacuated by their thoughts about the process of giving birth. Steph, for instance, said her experience had become "all about the baby now. The whole giving birth thing, that's tucked right away now really. Now I'm just thinking about...when the baby's out." Likewise, Karen said "I just can't wait to meet the baby. That is everything now." Jo also spoke of "just holding out for the moment of meeting him now". All Kate could think about, she said, was "the moment bubs is out and I first lay my eyes on him or her".

Rehearsing

The second sub-category of **Travelling a new path blindly** was about how women tried to develop a comprehensive idea in their minds of how the procedure might go. Labelled **Rehearsing**, it presents the strategies women undertook to deal with their fear, terror and anxiety and their quest to develop a comprehensive understanding of how the procedure might play out for them. Women described trying to envisage how they might feel, what they might be thinking about, and how they would behave during the surgery. This they did continually in an attempt to become clear about what would take place. Trinny, for example, said she had "run through it a lot in (her) mind, trying to get a feel for what it'll be like". Jan, similarly, had "gone over and over and over it trying to imagine it". Karen, too, stated she had "given a lot of thought about how it will all happen".

Despite spending a lot of time mentally rehearsing the caesarean section, women found it very difficult to clearly determine what their role would be in the operating theatre. By the time the day came around, the only decision all women had made about what they could usefully do during the procedure was, simply, to keep as still and silent as possible. Jan's comment was typical. She said,

I have thought it through and thought it through, and I just can't see there is anything for me to do. Except just literally lay there. It's all gonna be taken care of by (the staff). There will be literally nothing for me to do.

When women made mention of planning to “control”, to “behave” or to “contain” themselves in the operating theatre, they explained it in a context of not being able to find, and not being given, any other role for themselves. They also, however, presented this as a way of making life as easy as possible for the surgeon and other staff. Women conjectured that by providing the surgeon with a “fixed target”, as Rose put it, they could help make his or her task more straightforward and less complicated. By planning to, for example, “stay still”, “keep quiet” and “not move a muscle”, women felt they would be able to, “help to make things go smooth” (Sally) Women didn't want to, for instance, be the “cause of (the doctor) losing concentration” (Adrienne), or “to be a distraction in any way” (Jeanne).

Women only planned to invoke this state of “suspended animation”, until their baby was born though, after which they intended to begin being their baby's mother. Women did envisage there would be limitations to their ability to take their baby. Jeanne said, “it'll be hard to hold her when I'm laying flat”, Tina guessed “it'll be tricky lying down”, and Kylie had a friend tell her to “expect it to be a bit of a challenge because there will be tubes and wires everywhere”. They were not deterred by these anticipated limitations though, and all spoke about their yearning to finally meet and care for their baby. Madeleine's comments reflected the other women's strong desire and intention to be their baby's protector,

you know...I'll be flat on my back that I won't be able to do much of whatever, but I just think, well, you've just got to find a way. I just think, well, however difficult it is, I want to at least try and have her with me... Reassure her, let her know, you know, she's safe, Mummy's here, sort of thing. Because...well I'm the only mum she's got. It should be me who's there for her [has tears in eyes]. No-one else will look after her like I will.

As well as trying to foresee how they would feel, think and behave during their caesarean section, women also tried to imagine the practicalities of the procedure, for example what the atmosphere would be like, how the surgery would be performed, and what the other people in the room would be doing. Although two women had been in an operating theatre in a professional capacity none had ever been in to one as a conscious patient, and though many had an idea of what it might be like, their impressions of the physical environment were largely constructed from media images

or other peoples' descriptions.

When women thought of the operating theatre, they said they imagined it as a business-like environment and that it would be quite quiet, but that there would be a “hum of activity” which would include, for example, chatter and machinery noises. For many this combination was associated with what Jeanne, for example, termed “a feeling of efficiency”. Almost all of the women identified that they expected, although they would be lying down, that they would be the centre of everyone’s attention, and that all attention would be focused upon them. Women said they expected they would be constantly reassured, kept involved and kept informed by staff. Many women and partners commented light-heartedly about the need to get “dressed up” in operating theatre attire. All said that they thought the procedure would be quite quick, and that they would see their baby very soon after the operation started. Some women talked of being aware they would be screened from the operation and the surgical team by a green drape, and the majority of women expressed indifference to the presence of this drape. Sally, however, who had a history of an anxiety disorder, had the impression that it would be positioned across her neck and be very close to her face; as a result, she worried extensively about feeling “closed in...a bit claustrophobic...a bit panicky” throughout the procedure. Kylie, who was very fearful of the procedure, said she planned to just hide away behind the green drape “‘til they tell me it’s all over”.

Summary

In this chapter, the reader has been introduced to the first two categories of the core problem of **Being Made Redundant** and the BSPP of **Regrouping**. It was explained that becoming in need of and awaiting a caesarean section meant that women experienced **Feeling robbed**, specifically of their stability, security, confidence, autonomy, visibility to health care professionals, their centrality in their birth experience, and of the ability to optimally bond with their baby in the moments after his or her birth. To one woman, having a caesarean section threatened to rob her of her uterus and therefore her future fertility, while another seriously considered she could be robbed of her life during the procedure. Although some women received some empathy from others for their situation, they essentially found that needing a scheduled caesarean section was associated with **Becoming a ‘persona non grata’**

in many peoples' eyes and overall, they found themselves dealing with it alone.

Given the temporal nature of the experience, the first two categories of the basic psychosocial process of **Regrouping**, labelled as **Trying to make it feel real** and **Travelling a new path blindly**, were then reported. These categories convey just how much mental and emotional work women put into trying to keep abreast of the changes that were happening to them. It is clear from the data that, once they had recovered a little from the initial shock of realising that they would need a scheduled caesarean section, women's sole focus became fact-finding. In particular, women sought information from a variety of sources (including online, printed media and human resources) that would verify the decision for a caesarean section was truly justified, that would help them work out how they felt about it, and that would assist them to get to know, understand and prepare for the procedure from a physical, mental, emotional and behavioural perspective. Unfortunately, despite their efforts, women found that the information they needed was largely not available, and so they moved to conjecture as the means by which to prepare for their caesarean section. The ways women experienced and managed having their caesarean section and the early post-operative / postnatal period are described in the following chapter.

Chapter 5

Birth and Beyond

It was...aaahmmm...yeah, not what I expected. Definitely... mmm...weird. Very impersonal. Bit of a production line. I might as well have not been there, really, if you know what I mean. I did try and get involved a bit but I couldn't speak! I was trying. In my head I was like, "Hello? Anyone? Over here." [waving], but it wouldn't come out! I couldn't get it out! Yeah. Very unfunny. I didn't like it.

Donna, 3 hours post-caesarean section

I still go over it all the time. Did I need it? Was it necessary? Yes, it was necessary. Ok, so why do I feel so yuck about it? Da di- da di-da... over and over. I've got a beautiful baby but, I don't know what it is... I have a baby, but did I have the baby? And while I'm puzzling over that, trying to get all that straight in my head, she's getting on with it, you know, growing, changing, being amazing generally, and I'm not really seeing it really. My mind's not really on her a hundred per cent of the time if I'm completely honest. Yeah. Like, I get it all worked out, all straight in my mind and I think that's it, but then I get into it again! Maddening. So frustrating.

Dee, 11 weeks postnatal

Introduction

In this Chapter, the third and fourth categories of the core problem are reported. Labelled **Off everyone's radar** and **Left wanting**, these categories depict how women experienced the day of their caesarean section, and the first 10 to 14 weeks postnatal. Simultaneously, the related stages of the basic psychosocial process of **Regrouping**, labelled **Striving to be included but trying to behave** and **Treading water**, provide the reader with an insight into the way in which women tried to manage and process this aspect of their experience.

Off everyone's radar

This third category of the core problem represents women's sense of invisibility and superfluity on the day of their baby's birth. It comprises two sub-categories. The first,

labelled **Just another case on an operating list**, characterises the depersonalisation and objectification women felt as they were referred to throughout the day of their baby's arrival either as a number, as a caesarean section, as the condition that had necessitated their caesarean section, or simply as 'next'. The second sub-category of **Off everyone's radar**, labelled **Unable to be my baby's mum**, describes how women's invisibility and fear, as well as the operating theatre routines and regulations, prevented them from taking up their maternal role once their baby was born as they had hoped and planned

Just another case on an operating list

Having felt usurped by the caesarean section during the time leading up to their baby's birth day, women reported that by the time the procedure came around, they felt almost completely invisible. As Janine said, "it was like (she) was there but (she) wasn't there". In contrast with their supposition that they would be treated as special on the day of their baby's birth, women reported that from the moment they first presented at the hospital on the morning of their caesarean section procedure, they felt unimportant and unseen as an individual. Jan, similarly to other women, said that while she "didn't expect balloons and fanfares, (she) did at least think (she'd) be welcomed warmly, greeted by name..." As had been the case antenatally, women reported that the caregivers they encountered were polite and attentive, but that they were distant and impersonal, and that their focus was all on the process, the procedure, and related paperwork and tasks. Data analysis revealed that this was women's experience from the moment they arrived at the facility. Typically, women were moved through seven different areas of the hospital (and met seven different groups of personnel, all of whom were unknown to them) between arriving at the hospital at 06.30hrs and reaching their final destination – a postnatal ward – later in the day.

Women reported that this experience of being conveyed to one place after another to wait was "dehumanising". Having to wait in an operating theatre gown with their luggage by their side, in a common area with other day patients for perhaps hours was "really undignified", they said. Additionally, women said it was "degrading" to hear themselves "referred to as a number", a theatre time, or a condition such as "the placenta praevia", or "the breech". Figure 19 provides an excerpt from the data collected from my non-participant shadowing of women through the day of their

caesarean section, and describes one participant's 'journey' through the hospital. This data exemplifies all of the other days (n=11) I followed women, and quite clearly demonstrates that women did indeed receive care that resembled being on a conveyer belt.

06.32 Cherry arrives in hospital foyer alone... Takes seat in row of chairs in ED – two other heavily pregnant women with cases already there.

06.35 ...A woman in a white tunic and navy blue pants arrives. She's holding a clipboard. She goes along the row of women and asks "caesar?" to each. When all are checked off, she moves toward the lift and says "OK let's go"...

06.45 Party arrives at day surgery unit... women given a hospital gown... shown to a changing room. Each is shown to a toilet and asked to provide a urine sample, then told to come to the common waiting area. Cherry's case is picked up by yet another different staff member, and placed on a trolley. Cherry asks where it's going, and is told "to your ward". Cherry nods.

07.00 More staff arrive

07.10 One of the just-arrived nurses picks up Cherry's file and calls her name. She smiles warmly at her, and takes her to a smaller room...She asks "you're the breech, yes?" When the nurse has all the information she needs, she gives Cherry a few instructions and asks her to go back to the waiting area until she is collected...

10.35 Two people in operating theatre clothes come into the waiting area. One (a woman) calls Cherry's name, greets her warmly, tells her "it's time", and that she's going to take her to the theatre holding bay. Cherry follows her, and I hear the other (a man) tell Cherry's husband that he'll take him to get changed into theatre gear. They leave the day surgery unit.

11.00 Two different people in theatre clothes come into the holding bay. One greets Cherry and tells her that she's come to take her to the anaesthetic room. The second tells her husband he's going to take him to a different room, where he will have to wait until Cherry's anaesthetic is done. They leave the holding bay. Cherry is greeted in the anaesthetic room by three staff members she hasn't met before.

11.20 Cherry is moved from the anaesthetic room into the operating theatre... husband is brought in. A midwife Cherry's never met before arrives soon after...

11.32 Baby Aaron born

11.55 Cherry is moved to the recovery room by two different men (orderlies).

12.35 Cherry is collected from the recovery room by a different midwife, and taken to the postnatal ward.

Figure 19. Excerpt from non-participant observations - Cherry's journey through the hospital on the day of her caesarean section

As previously reported, women found it enormously difficult to determine their role in the operating theatre, given that they would be both a birthing mother and a surgical patient. They worked hard during their pregnancy on rehearsing what having the caesarean section might be like and, despite being unable to secure much information on how it might actually 'feel' or what was expected of them, all came to the eventual conclusion that, to meet the needs of everyone involved (that is, the surgical team and the baby), they would invoke a state of calm, controlled, quiet, still inertia during the procedure until their baby was born. They expected that they would then re-emerge from that state to become their infant's protector and carer in whatever way they could.

At that time, women's assumption had been that the focus of the staff involved in the procedure would be to honour and foster the sacred mother-baby relationship. This, however, was far from the reality. Instead, women clearly felt that the procedure was undertaken and concluded efficiently, and that the day's operating list was completed in a timely manner.

Once in the operating room, rather than being the focus of everyone's attention as they had expected, women described feeling unnoticed for almost the entire procedure. As a case in point, Keira's sense of feeling "like part of the furniture" was shared by many women. A plethora of other examples of their non-acknowledgment was also forthcoming in the data. Many remembered, for example, instances of gowned, masked people walking past them and performing tasks as they lay on the operating table, without looking at or speaking to them. In Julia's and Anne's case, one of these people had turned out to be the surgeon. They deduced this only because, without acknowledging them, the person had begun operating on them. Such incidents were supported by my own observations. The following excerpt from my observational notes (Figure 20), made during Anne's caesarean section, confirm the women's recollections.

Kylie recalled hearing a door behind her squeak as it opened, and a man in full theatre garb coming to stand beside her and start chatting to the staff in the room about another woman on the day's list while she was being operated on. She recalled "it was as if I didn't exist". Fiona also remembered that "people just came and went past me like I wasn't there".

09.32 man in full theatre gear (obstetrician??) walks in from scrub room. Walks past woman on her L(ef) H(and) S(ide)...continues to end of table. Stops briefly and reads something on shelf ?woman's notes, ?theatre list. *Noise from B(lood) P(ressure)machine: <'bip'...'bip'...'bip'...'pfooooooosh'>* same man continues walking round end of table, walks up R(ight) H(and) S(ide) of table. Looks at / speaks to no-one. Stands beside woman's abdomen (other side of raised drape – woman, partner can't see him). Looks around. Scrub nurse offers a ?kidney dish to him. He picks up knife. Begins to cut into woman's abdomen...

09.35 W(oman) to P(artner): "Have they started?" P(artner) shrugs, looks up to A(naesthetist): "'scuse me. Mate?". A(naesthetist) looks over, smiles, raises eyebrows. "Sorry. Has it started, has it?" A(naesthetist) looks over drape, looks back at P(artner): "Yup" (nodding). (P)artner to W(oman): "They've started love". W(oman) bites lip, looks at ceiling.

Figure 20. Observational note: Anne's caesarean section

All the women described feeling like they were "on a production line". Women reported becoming acutely aware that, whilst they were still on the operating table, the next 'case' was waiting in the anaesthetic room. Participants knew this because the majority of staff members' conversations around them became about the "next case". These perceptions were reinforced by some personnel, typically the anaesthetic technician and the anaesthetist, beginning to move between the operating room and the anaesthetic room to attend to both the woman on the operating table and the one waiting.

Women did recall one group of staff as more attentive than others; anaesthetists and anaesthetic technicians. All of the women described these personnel positively, saying they were, for example, "kind", "lovely", "there for me" and "very reassuring". Women also described these professionals as more available to them than others during the procedure, although there were still times when they couldn't connect with them. Typically, this occurred either because the anaesthetist had moved away from the women, or because the woman couldn't move her head sufficiently to locate him or her.

Unable to be my baby's mum

The moment women became aware that their baby was born all said that their fear and anxiety disappeared as they had thought it would. These feelings were replaced by instantaneous love, deep connection, problem and protectiveness for their newborn. All of the women described a wave, or a rush, of pure, ecstatic joy and an

immediate strong yearning to have their baby in their arms. All recalled being surprised by the fierce protectiveness and the intense physical urge to hold their baby that they felt. Adrienne said it was “like (her) whole body ached to have (the baby) in (her) arms”.

In all cases, though, women were made to wait some minutes before being able to hold their baby, as he or she was first ‘examined’ by a neonatologist. Regardless of whether the baby needed any medical assistance or not, the surgeon retrieving the baby would hand him or her to the neonatologist waiting at the end of the operating table. This doctor would then take the baby to a resuscitation cot, also located at the foot of the operating table, for observation, assessment and ‘routine’ treatments (for example, an injection of synthetic Vitamin K, the application of a plastic umbilical cord clamp and trimming of the umbilical cord). The neonatologist or the attending midwife would then apply name bands to one of the baby’s wrists and one ankle, before wrapping him or her securely in two or three covers and taking him or her to the new mother.

Figure 21 is of a sketch made in the operating theatre during Donna’s caesarean section. It depicts the moment the neonatologist received Donna’s baby from the surgeon, just prior to placing him on the resuscitation cot. Although not unwell, the baby remained on the resuscitation cot, which was positioned at the foot end of the operating table out of the sight of the baby’s mother and father, for several minutes. This scenario is typical of all of the other caesarean sections I observed.

At some point after the baby had been moved to the cot, and before he or she was taken to the mother, the second parent would be invited over to meet the baby and perform the rite of cutting his or her umbilical cord. In every case, women and their partners recalled this invitation to have created a brief but very significant dilemma. Not wanting their baby to be alone, women remembered encouraging their partner to go, however at the same time they felt profoundly sad that they couldn’t be part of it. Partners also remembered feeling torn between not wanting to leave the woman alone and going to the baby to fulfil the cord-cutting rite. In all cases, the woman’s partner did go to be with the baby, however both women and their partners reflected extensively on this episode postnatally. They talked about it feeling very wrong that it was not the baby’s mother that met and touched him/her first, and that they didn’t

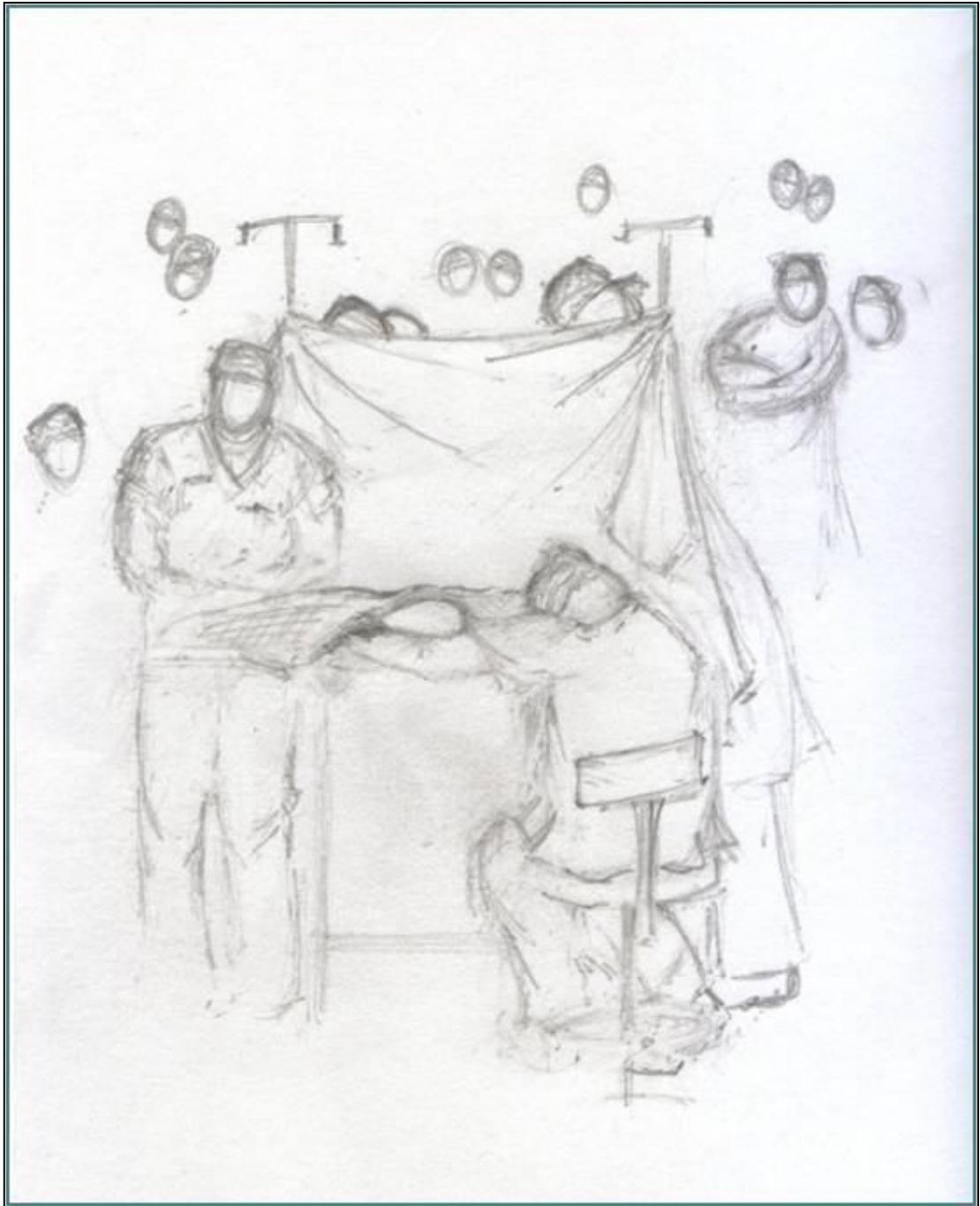


Figure 21. Observational sketch of Donna's baby being received by neonatologist

welcome their baby together. For Kylie, like other women, this specific non-inclusion in her experience epitomised her sense of redundancy, and is characterised by the following statement: She said that “the whole thing made (her) feel like (she) was just an incubator. Job done, see ya [sic] later”. The non-participant observational sketch in Figure 22 is of a Rose, now a new mother, being left behind by her partner as he goes to be with their baby.

Although in many instances, the surgeon held the baby up over the drape for a few moments for women to see before handing him or her to the neonatologist, most women recalled still gathering their thoughts at that point, and of not really ‘registering’ their infant. It was observed to be between three and six minutes before women were afforded the next opportunity to have any contact with their baby.

These lost few minutes were the subject of much deliberation and lamentation for women when I spoke with them at 10 to 14 weeks postnatally. For women, those few minutes represented an excruciatingly stressful length of time that constituted a gap in their knowledge of their baby’s life. Women told of how, already tense, their anxiety levels rose as they waited to meet their baby; the delay was seemingly interminable. Tamsin said she “started thinking all sorts was wrong” as “no-one told (her) anything what was happening [sic]”. Likewise, Karen said her “imagination started running riot” when she “couldn’t see him, couldn’t hear him and no-one brought him to (her) or said he was fine or anything”. Both women and their partners referred to this time as, for example, “a missing part of our family’s story” (Dee), “moments of (their baby’s) life that are lost to me forever” (Jan), “precious, precious minutes (his wife) can never know and can never get back” (Lee) and “a part of (their baby’s) life that (his partner) has no idea what went on” (John).

When I asked maternity health professionals about the time between a baby’s birth and their mother getting to meet them, their view of it was very different than the women’s. All, without exception, spoke of it as a brief, insignificant interlude that represented “no time at all, just a few minutes if that” (Obstetrician Tim), and failed to recognise its importance to women. Neonatologist Mark said the delay was, “unavoidable. I have to do what I have to do. And you never know what you’re going to get but usually... (shrugs) ... routine stuff. Done and dusted very quickly. Hardly

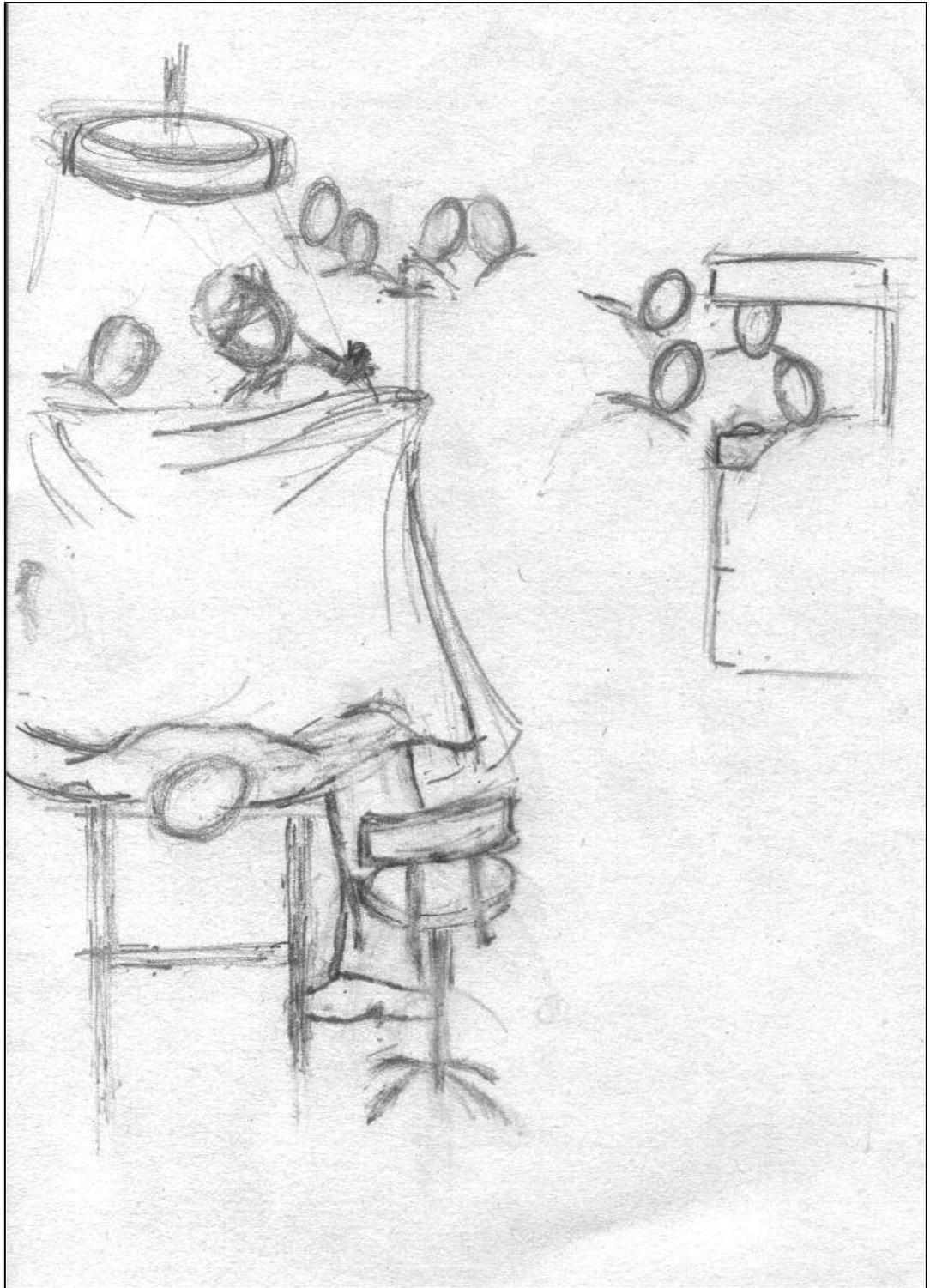


Figure 22. Observational sketch: New mother Rose left alone in the operating theatre

any time at all.” Similarly, Midwife Mandy said

I do whatever’s necessary, you know, er... quick check over, get dad over to do the cord, labels, vit K, hep B, whatever, don’t muck about, and I get that baby to mum as soon as I can. She’s not missing anything. If it comes out pink and yelling, it probably takes no more than two or three minutes at the most (shrugs).

In most cases, once the baby had been brought to the woman, only a very short period of time elapsed before they were separated again. In all but one woman’s case, babies were transferred to the postnatal ward with their other parent before women’s surgery episode was complete. This second separation also created an angst-ridden situation for both new parents as they inevitably faced a wait of unknown length before their family was reunited.

Striving to be included whilst trying to behave

In response to feeling totally invisible in the operating theatre, the data in this category reports how women responded in the operating theatre to what, for them, was evidently a dichotomous situation. It became clear very quickly that those undergoing the procedure regarded it as both a birth and an operation, but that for those involved in performing caesarean section, it was regarded solely as a routine surgical procedure. It was also evident from the start that neither party had any degree of awareness that the other saw the situation as they did. Women also greatly underestimated how fearful they would be once they were actually in the operating theatre and lain on the operating table, and how paralysing their fear would be. Together, their entrapment in their state of fear, their invisibility as a birthing mother to those caring for them, and the routines and processes of the operating theatre meant women were unable to execute their plans. **Striving to be included whilst trying to behave** is the third stage of the process of **Regrouping**. It explains the women’s efforts to turn their situation into a more engaged, positive and meaningful experience.

In contrast to their expectations, once they were on the operating table, women found that they were effectively unseen, or perhaps forgotten, by those around them. Women reported that if someone spoke to them, it was very brief and in passing. Women perceived that no-one focused on them for any length of time, supported them throughout the procedure or kept them informed. As a result, women described

feeling incredibly tense. As they had planned to, women said that once they were on the operating table they began to 'submerge' into a state akin to almost complete physical, emotional and mental suspended animation. It was not the state of serene, anticipatory tranquillity they had imagined prior to surgery. What they described was fear-induced total paralysis. For example Trinny said "I was so nervous I just completely froze". Jo recalled feeling "so frightened I could not move a muscle." In the same vein, Anne described it as like "being trapped inside myself".

As the operation got underway, women recalled feeling their body shake, hyperventilating, feeling nauseous, dizzy or faint. Trinny described thinking, "my heart would burst out of my chest any minute", and of being very frightened by it. Many remembered trying to calm themselves down while simultaneously trying to bring themselves out of their inert state to catch someone's attention for "reassurance that all was ok" (Sally). Jo explained how she "felt like (she) was gonna [sic] pass out", and said she "tried to just do some deep breaths, sort myself out, but really I just wanted someone to notice and tell me I was ok but I couldn't catch anyone. I tried and tried". After some moments, Jo's expression became grave, and she added, "That feeling that you are completely on your own and sinking...that was really, really scary actually." Similarly, Keira had an episode of "feeling faint" and "tried desperately to come to, you know...I wanted to know was it normal to feel like that".

For many, it was some time before they could emerge from their withdrawn state to try and get noticed or secure a response. Even women's partners, who commonly were sitting very close to and touching them, largely failed to see when women sought recognition or attention. The quote below, about Jan's attempts to make contact with her husband when she suddenly felt unwell and frightened, is a good example that illustrates this stage of the basic psychosocial process undertaken by women,

As [the caesarean section] began, I just, I don't know... I went off somewhere in my head. I remember just saying to myself in my head..."breathe in, breathe out". I was completely out of it. Then out of the blue I felt really, really strange. Really weird. I thought I was going to pass out or something, and then I was back with it, back in the room so to speak. And I felt really panicky. Really, really scared. And I couldn't speak, the words wouldn't come out. I remember just staring at my husband, trying to make contact with my husband, but he was talking with the anaesthetist. No-one else was looking my way. No-one was

noticing me! (laughs, looks incredulous). For ages. Or...well it seemed like ages. I...honestly, I thought “any minute I’m going to black out and no-one is noticing. Finally my husband looked down at me and must have realised I was a bit off, and told the anaesthetist, and he said something about my blood pressure going...and that he’d given me something for it but I didn’t know that, I thought they just hadn’t realised.

The observational sketch in Figure 23 is of Jan, and illustrates her attempt to make eye contact with her husband, who was deep in conversation with the anaesthetist.

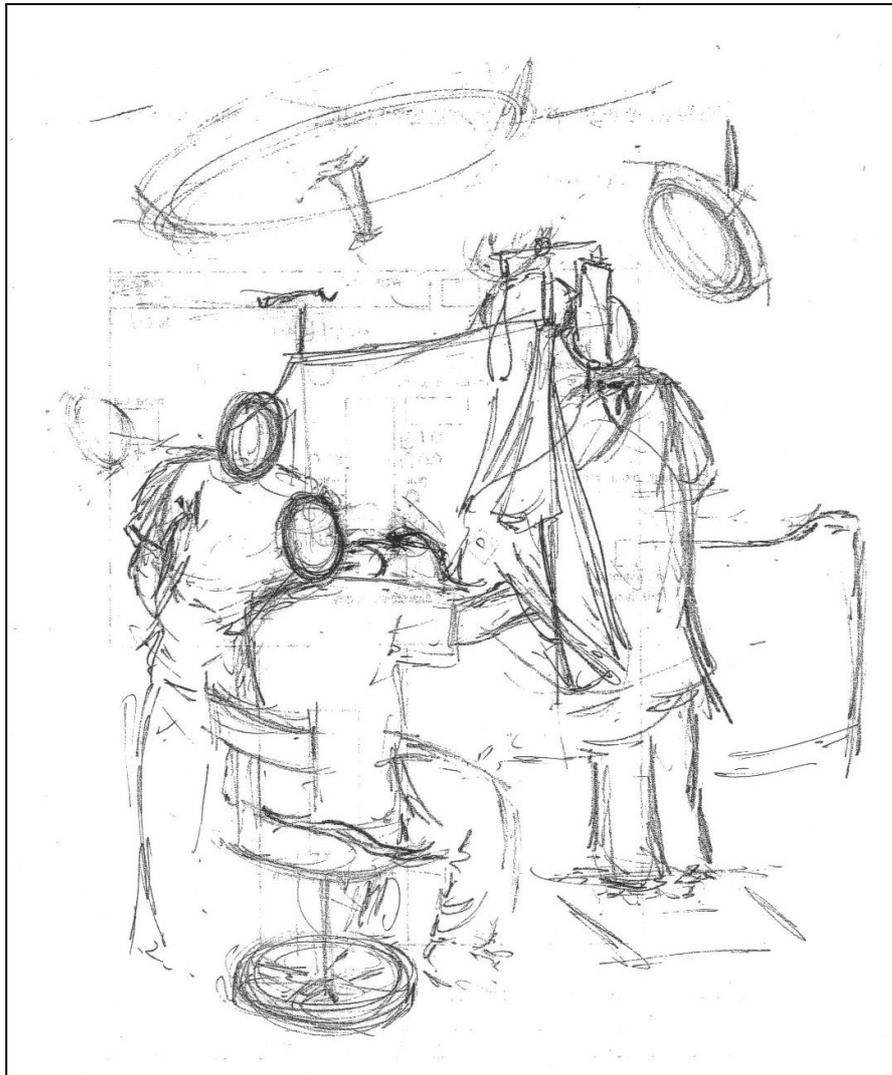


Figure 23. Observational sketch: Jan, frightened, trying to make eye contact with partner

Women said that at the same time as trying to seek reassurance that all was well, they tried to maintain a state of motionlessness and silence as they had planned to, but that doing so was extremely difficult. Sally, like others, said, “I felt like I was

hyperventilating and I tried really hard not to breathe too deeply”. Madeleine and Donna both recalled worrying about causing problems when they began vomiting intractably, with Donna going on to add that she “just felt crap for holding everyone up”. Women spoke of trying but being unable to stay ‘completely still’, which generated a sense of failure and guilt. Yvonne, for instance, described how distressed she felt at the thought of making it difficult for the doctor when she “started to shake uncontrollably”. Dee panicked about putting the surgeon off when her “chest heaved” as she sobbed with fear. Her feelings were compounded when she recalled seeing the surgeon “stand back and fold his arms like he was waiting for me to... I don’t know, behave, or get over it”. She followed this statement up by reflecting, “I felt like I’d put him in a mood, and fair enough, he probably just wanted to get on with it”.

Once they became aware that their baby had been born safely, many of the women described trying desperately to hold back spontaneous tears of joy and relief whilst simultaneously trying to and to suppress the involuntary movement of their arms that occurred. Although they had never been told they must stay completely still, women’s efforts to inhibit these natural impulses were borne of an assumption that any movement would cause problems for the surgeon. Keira’s experience was similar to many other participants’. She described the struggle to control herself thus,

I heard this little tiny mew and then... oh lots of biiiig [sic] emotions. It felt like my heart was going to just burst! My whole body spontaneously jumped in that moment and I just burst into tears but I knew I had to stay...keep still so I was fighting it. It took all my might I can tell you.

As previously reported, when their baby was not brought to them instantaneously, women reported that their already high anxiety rose even further as they worried whether everything was all right. Again, they commonly described consciously struggling to curb their natural instinct to try and see what was happening with their infant. My observations support this. I repeatedly noted how women very tentatively craned their necks in an effort to see to the other end of the room where their baby was, and the return of their gaze to the green drape in front of their faces when their restrained efforts proved fruitless. Women talked about “pushing it as far as (they) could” to reassure themselves of their baby’s wellbeing, but as they had earlier, said they voluntarily restricted their movement out of problem for the surgeon. When their efforts were unsuccessful, the majority were observed to give up trying and to

look at the ceiling instead. Only one woman, Madeleine, said she was successful in glimpsing her baby's foot, and recalled that once she did, she "just felt so relieved to see it was pink and moving about", and that she "could relax then."

When eventually women were provided with their baby, it seemed to them only moments before they were parted from them again. Many recalled trying to gain more time together with their partner and baby before being separated: Tina, for instance, said she "was naughty – (she) tried guilt-tripping the midwife". Similarly, Karen said she "did a bit of a charm offensive, a bit of bargaining" to keep her baby with her a little longer. Trinny, too, said she,

had a good go at stalling, I can't remember exactly how, I think I just kept asking stupid questions, not that I was listening to the answers, I just kept looking at the baby, you know, trying to get an imprint of her on my brain cos [sic] I knew I wouldn't see her for a while.

Left wanting

This last category of the core problem is about how women responded to their infants once they were reunited with them. By the time they were moved from the operating theatre department to the postnatal ward up to two hours after the baby's birth, many women described feeling differently towards their baby than they had in the operating theatre. Almost all recalled feeling their initial, almost primal, yearning, protectiveness and problem for their baby dissipate during the time they were apart from them. The loss of these feelings, and the sense of disconnection and indifference they felt instead, was something that came to bother them a great deal in later weeks. The following quote from Steph at 13 weeks postnatal is a powerful example of this,

by the time I got back to the ward, I didn't feel so strongly about (the baby). It was really bizarre actually. I had been like mother bear or something when she first came out, you know, like an hour earlier or something. But then when I got back (to the ward) I didn't feel like that at all. I just didn't feel any connection to her. I was sort of aware there was a baby there in the cot but no, nothing. No great urge to see it or anything. I think it was even crying at one point, and it sort of registered but I didn't feel like it was anything to do with me. In fact now, I remember getting a bit irritated and thinking "is someone going to sort that out?" (laughs). I certainly didn't feel any great urge to do anything about it"

Steph's response was not isolated. A number of women talked about knowing their

baby was crying or in need of attention but of feeling neither an emotional reaction nor any sense of responsibility for attending to or comforting them. Others relayed their lack of feelings for their baby in terms of their experience of feeding them. All of the women opted to breastfeed, however many felt numb even while their infant was attached to the breast and suckling. Most of the women were still breastfeeding at the time I interviewed them at between 10 and 14 weeks postnatal, however many still did not feel strongly connected to their baby at that time. Many talked of caring for and nourishing their infants as “routine”, “automatic”, or “just going through the motions”, but of having optimism that eventually they would recover their lost sense of attachment to them. Rose, for example, laughed when she said she was like “robot woman”, however she then became quiet and pensive. After a few moments, she looked away, nodded, and said it again more seriously: “Yes, bit of a robot mother at the moment. We’ll get there though. Hopefully. It’ll come”. Tina said that although her lack of connection to her baby son worried her, she was optimistic that she could feel “like that” about her baby again “because (she) did when he was born”.

The loss of their feelings for their baby concerned women greatly, however it was but one aspect of a bigger picture of general dissatisfaction with and disconnection from their whole birthing experience. All of the women described their baby’s birth day as far less momentous than they had imagined it would be, particularly when they thought back to how they had envisaged it prior to becoming in need of a scheduled caesarean section. Each of the women made some mention of the fact that they were thankful for and glad to have their baby, however for many, their baby was the only positive aspect of the experience. One woman who had been fearful for her physical wellbeing and her future fertility was additionally grateful that she, as she put it, “came through it relatively unscathed”. Another, who had feared dying during her caesarean section, said she “gave thanks every day that it was all ok”. Over and above being thankful for their baby, though, none of the women spoke favourably or fondly about their experience; all described harbouring a degree of unresolved wistfulness about having to have a caesarean section, about their lack of involvement in it, about the time they missed at the beginning of their baby’s life, and about their loss of connection with their infant. Compounding their sense that scheduled caesarean section had left them wanting was that they felt they were regarded, or were actually treated, with caution, condescension or disparagement by other

mothers. Many cited instances of scheduled caesarean section being discussed disparagingly within their 'mothers groups', or of being treated warily or piteously by other mothers. The majority said they felt less of a welcome, less included in their new mothers groups than they perceived those who had given birth vaginally to be.

Overall, the women spoke of the entire episode of anticipating and having a scheduled caesarean section with indifference, a few to the point of disdain. The women emphatically described it as a wholly unsatisfying experience. Fiona, for instance, said she "couldn't say it had been fulfilling in any way at all". Jan assessed it as "just a bit 'hmmm' from the start until now really". Tamsin described it as "all a bit sobering", Trinny said that as something she had been so looking forward to, it had "fallen way short of the mark". Adrienne said that there hadn't "been anything about it that's been particularly great, or "wow"..."

Treading water

In response to their unsatisfying and disturbing birth experience, women engaged in a process of mentally 'recycling' each aspect of their childbearing episode. **Treading water**, the last category of the **Regrouping** process, captures the intense emotion work undertaken in an effort to resolve the many unanswered questions women were left with. Women described repeatedly reliving their experience to try and settle their lack of contentment with it, but getting nowhere fast. Dee and Tamsin, for example, spoke of "going round in circles" and "going over and over it". Others talked about feeling "stuck" (Jo), and unable to "move on" (Jan).

Women reported spending a disproportionate amount of time thinking about and reviewing all the events connected with their caesarean section, and identified a number of issues they were still wrestling with. For example, many women were still, at the time of the second interview, trying to put a name and a meaning to what it was they had experienced. Yvonne for example, said "I don't know whether I say I've given birth, I've had an operation, or what". Similarly, Tina said she repeatedly asked herself the question "Can I really say to her that I gave birth to her?" For Kylie, like others, the issue was an existential one, as she wondered whether having had a caesarean section "makes me a real mother? A real woman even?"

Women described being preoccupied for long periods with reflecting on, puzzling

over and trying to make sense of, every aspect of their scheduled caesarean section. They continued to speculate, for instance, just as they had done when the decision was first made, whether the reason for it was valid. As other women did, Trinny (who had previously had surgery to her cervix) voiced this problem soon after her caesarean section when she said “I’m still wondering you know, if I really *had* [original emphasis] to have (the caesarean section) done”. She remained unconvinced and troubled by it when I spoke with her some weeks later. At that time she again said “I’m still not certain (the caesarean section) was entirely necessary”. Reviewing the validity of the decision was, seemingly, not an occasional occurrence for women: many said they puzzled over it frequently. As Cherry said, “I go over it often: *did* I need it? Did I *really* need it [original emphases]?”

Women also continued to ponder over their lack of involvement in their caesarean section and their subsequent feelings of displacement and invisibility. Although they had come to the decision to subjugate their own need to make their birth experience meaningful and prioritise what they guessed to be the needs of others (specifically the staff and the institution, and the baby) prior to having their caesarean section, women were seemingly very unsure about the wisdom of this course of action when they came to revisit it postnatally. For many, this involved rationalising that if they had only known more about the whole process, they could have been better prepared and more involved. A few women, though, stood by the plan they had made to effectively disappear during their caesarean section and absent themselves from their baby’s birth. These women maintained the stance that it was, as Madeleine described it, “no big deal”, and that they “couldn’t do any more in the circumstances” (Cherry).

I also heard from a number of women that they felt discomfited by the fact that their anxiety got the better of them during the procedure. They replayed the caesarean section in their minds, in an attempt to understand, rationalise and validate those very intense, powerful and frightening thoughts and emotions. For the most part, revisiting their intra-operative fear was considered a way of trying to understand it and reduce its impact. Janine, for example, said, “maybe it wasn’t as bad as I think it was.” For Donna, though, this investment was about trying to work through the embarrassment she felt at not being able to overcome her fear in the operating theatre. She said, “I felt totally mortified that I was such a bloody great big wuss”, and that she “cringed” every time she thought about it, which she said was “often”.

The aspect of their experience that women dwelt on most, however, was the perceived loss of connection with their newborn. Many of the women talked with frustration and at length about trying to recall the deep attachment they had initially had to their baby, either by replaying the moment when they felt it, or by trying to invoke the sensations. Keira spoke of going so far as to “recreate the scene”, which she explained to mean that she would sometimes lay on her back with her arms outstretched and her eyes closed, and try and imagine hearing her son’s first cry. For some though, like Jan, reliving the caesarean section to try and recapture a connection with the baby brought about mixed emotions, as it meant “going through all the yucky stuff to get to the good bit”. Ironically, women were acutely aware that the time they spent thinking about these issues was time they were not focused on their infant. They talked of feeling frustrated and resentful that, having robbed them of so many elements of their childbearing experience, the caesarean section continued to demand, or as Anne put it, “steal” their time and attention.

Summary

In this chapter, the two major categories that represent how women experienced the day of their caesarean section and early postnatal period have been described. Interjected between these are the two categories of the basic social psychological process that represent the women’s desperate attempts women made to be involved in the birth and their baby’s early life.

It has been explained how, when the day came for women to have their baby, things did not eventuate at all as they had imagined they would. The lack of visibility to caregivers that women had felt since the decision was made to schedule a caesarean section was exacerbated, as was their non-inclusion in their own care. Additionally, women described feeling unable to execute their plans to remain controlled and still during the procedure because their fear and panic were too overwhelming. Nor did circumstances allow women able to contribute to caring for their baby as soon as he or she was born as they had wanted. The cumulative losses women incurred from having a baby by scheduled caesarean section, and their ‘recycling’ of their experience to try and make sense of it, have also been described.

How participant women experienced and dealt with scheduled caesarean section was moderated by a number of factors. Where one or more of these factors was absent,

women's experience of scheduled caesarean section was very different. In the next chapter, the moderating factors upon which the core problem and the basic psychosocial process are dependent will be reported, as will three negative cases that confirm the theory.

Chapter 6

Moderating Factors and Negative Cases

Introduction

Chapters Four and Five have detailed the core problem of **Being Made Redundant** and the interwoven process of **Regrouping** as constructed from the experience of 25 Australian women. The way these women experienced and responded to needing and having a scheduled caesarean section was dependent upon the four moderating factors reported in this chapter. Three of the factors, labelled **Expecting and wanting birth to be natural**, **Hurtling towards ‘D-day’** and **The green drape** each moderated a particular time period. The fourth factor, labelled **Caesarean section is hospital not women’s business**, moderated women’s entire experience of needing and having a caesarean section.

In addition to the 25 women whose data has already been reported, three additional women also participated in this research. Because of the absence of one or more of the moderating factors, each of these three women experienced scheduled caesarean section entirely differently to the other 25. These three women’s stories are also presented in this chapter.

Expecting and wanting birth to be natural

The esteem that the women held natural birth in was the first factor that moderated their response to needing a scheduled caesarean section; it was all 25 women’s hope and belief that their baby’s birth would be natural. Cherry and Julia respectively epitomised the women’s belief that this would be so when they said, “Look, I just thought I’d just have a baby” and “I thought it would just all happen as nature intended”.

As well as presuming they would have a natural birth, women also believed it to be best for their baby for a number of reasons. Janine, for example, said “it’s good for the baby to go through the birth canal”. Kylie talked about wanting her baby to “have all the good hormones”. Trinny expanded this argument, going on to say, “I mean everything that comes after depends on what’s gone before. Like, I mean, how feeding goes, the baby’s stress...all that depends on the birth, I mean nature not being

interfered with.” Others felt it was very important to allow the baby to “come when it’s ready” (Donna), or to “choose his or her own birthday” (Anne). Many of the women indicated that they thought the shared experience of labour and birth would strengthen their bond with their baby. In addition, a number of women rationalised that giving birth naturally would leave them with a sense of achievement and fulfilment, and that if they were satisfied and happy, their baby would benefit.

Natural birth was identified by the women as a significant personal growth experience that was as important to them as the baby they would have at the end of it. They spoke of giving birth naturally as a test of character, an arduous trial, which promised an opportunity for deep transformation that “turns you into a real woman” (Keira). Women alluded to feeling that their future self-esteem (and how they were esteemed by others) would depend on their behaviour, performance and success when faced with the trials they anticipated labour and birth would include. Kate identified labouring and giving birth naturally as a rite of passage, clarifying, “it’s a woman’s rite...I mean as in ‘r. i. t. e.’ rite, not ‘r. i. g. h. t.’, although I suppose it’s that too (laughs)”. Women were seemingly ready to embrace this challenge. Tina expressed that she was “looking forward to seeing what [she was] was made of and where it would take [her]”. Rose said she had been “like, bring it on! Test my mettle! Do your worst!”

These women described how they and their immediate social groups were distinctly unenamoured of the thought of “getting”, as Fiona put it, a baby by caesarean section. The data clearly conveys a shared feeling that a scheduled caesarean section offered no opportunity for personal growth. Women considered it would not be at all testing. They spoke of doubt that it would provide any benefits to themselves or their babies. Karen said just about everyone she knew “thinks [caesarean section is] a cop-out”. Kate said that “in (her) world, it’s cheating”. The procedure was constructed by Donna as presenting no test of one’s “grit”. Cherry reflected the sentiments of many when she said,

I just can’t see how (caesarean section) is particularly character-building when you just stroll in, lay down for a bit, other people do all the tricky business, and then you get a baby. I suppose my feeling is that you should work for it. That you kind of don’t deserve the reward if you don’t work for it.

These women found it incomprehensible that anyone might actually regard caesarean section as a better option than natural birth. Yvonne, who was having her first baby, told of meeting someone who “said she would much rather a Caesar [sic]. And I just cannot understand that. I mean, why? Why would you think that?” Rose, who also was becoming a mother for the first time, thought that women who preferred caesarean section “obviously just don’t know, do they? What they’re missing out on”. The esteem that these women held natural birth in was the first key factor that moderated their response to needing a scheduled caesarean section.

Hurting towards ‘d-day’

How successfully women managed adapting to and ‘working with’ the need for a caesarean section during the remainder of their pregnancy was moderated by the fact that the date for their procedure was set and, as Dee described it, “looming large”. Regardless of how much time women had between receiving the news they would need a scheduled caesarean section and actually having it, the available time was not enough to fully integrate the decision. For some women, the time they had to come to terms with the change of plan was very short indeed, only two or three days, while the longest a woman had to come to terms with the news and prepare herself was five weeks. The less time women had available to them, the more rushed, superficial and incomplete their endeavours were. This meant that women went into their caesarean sections still feeling confused, uncertain of its necessity and with many unanswered questions about it.

All women described feeling that the ‘deadline’ of the caesarean section date put them under pressure, and that they were “working against the clock” (Tamsin). The shorter the time frame, however, the greater the sense of panic, and the more women rushed or skipped over the actions, interactions and reactions involved in making the realities of the caesarean section sink in. In these circumstances, women described and evaluated their preparation as ineffective and incomplete. As Jan, who had only four days to prepare, said, “Time is ticking on, I mean, I’ve just got to get a grip on it.” Donna, who had five days to ready herself, said she could imagine “going in (to the operating theatre) still wondering what the hell’s going on, how did I come to be in here?”

All of the women spoke of wishing they had more time to prepare for their caesarean

section. Yvonne, for example, who found out she was having her baby by caesarean six days before she did so, said she “felt incredibly rushed, like I was just *hurtled* towards it... Or, as if *it* was hurtling towards *me*... I just could have done with a bit more time I think, to get my head round it [original emphases].” Similarly, when the decision for caesarean section was made for Fiona with four days notice, she described it as feeling like “watching the sun go down...nothing you can do to stop it”. Fiona went on to explain that she wished she “just had a bit longer to find the light switch, if you know what I mean”. Jan described a very powerful dream she had wherein she stood, unable to move, in the path of a “massive juggernaut” hurtling towards her. Jan felt her dream represented her “panic about how quickly the caesar’s coming up”. In the following quote, Adrienne, who was booked for her caesarean section 25 days prior, described how the looming deadline felt to her,

I imagined it like a giant, I don’t know, stick figure or something... in the distance that got bigger the closer it came. Coming towards me (raises arms, makes hands into claws). It’s like it’s coming, ready or not

As the date for their procedure drew ever closer, the need to “get on top of it” became increasingly urgent for the women. Many questioned how prepared they were. Where they had time to do so, women described cycling through the first and second stages of the psychosocial process described earlier (**Trying to make it feel real** and **Travelling a new path blindly**) again and again, in an effort to ensure they hadn’t missed anything. Tina, for instance, who had the longest of all participants to prepare for her caesarean section, articulated two days before it that, “even though (she had) been over it all a thousand times, (she was) still thinking through stuff. I mean, *is* it really necessary? How *am* I gonna feel in there [original emphases]?” Similarly Trinny, who found out at 36 weeks gestation that she would need a caesarean section, said she still felt-ill prepared with four days to go. She said,

It’s just about here and I don’t feel anywhere near like I’ve got to grips with it. No. Not had a reality check at all yet. They’ll be cutting me open and I’ll still be trying to get my head round it. I do feel a bit...um... all over the place, I suppose. Yeah. Not together at all

It is evident from this data that having an imposed, often very tight, time frame in which to make their adjustment to and preparations for their scheduled caesarean section was another fundamental factor in women’s experience of it.

The green drape

Moderating how all of the women both experienced and processed their time in the operating room was the presence of a fabric green drape erected across their upper body throughout their time in the operating room. Soon after each woman was moved onto the operating table, a sterile drape was suspended vertically across her chest, and attached to intravenous infusion support poles positioned either side of her. The suspended drape typically flared out some 30- 50 cm to women's left and right, and extended upwards to a height of about one metre. The lower edge of the green drape fell in loose folds over each woman's chest and arms. The way in which the drape was typically positioned is illustrated in the observational sketch of Rose on the operating table provided in Figure 24.



Figure 24. Observational sketch: Rose behind by the sterile green drape

Women described themselves as being 'behind' the green drape, and said this gave rise to feelings that their baby's birth was happening in a different place, "far away" from them. Women described this as like being "next door", "zoned off" or "as if I was in a different room". Tina provided a graphically different articulation of this by stating that lying on the table with the green drape in place was like being in a magician's box and "cut in half". She described feeling like her upper body was in one half of the box and her lower body in the other. As we were talking, Tina was sketching on a piece of scrap paper. The drawing she made is provided in Figure 25.

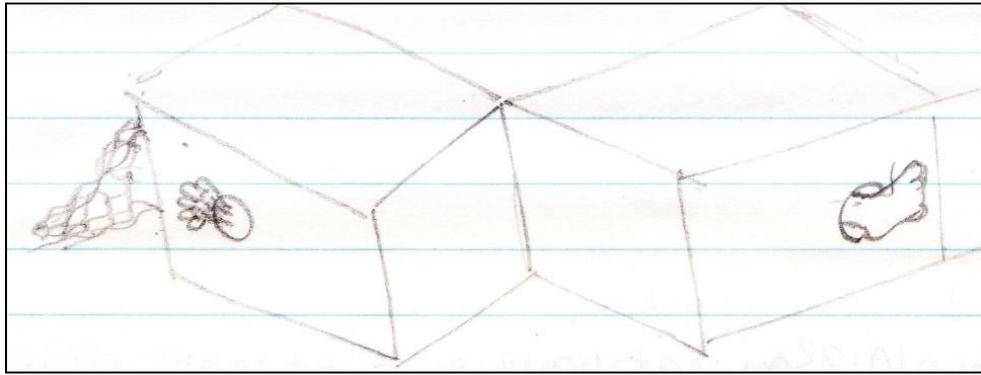


Figure 25. Participant (Tina's) 'cut in half' sketch

Women's perception was that the whole room, not just their body, was divided in two. This was due to two factors. Firstly, the majority of the maternity health care professionals present during each scheduled caesarean section were observed to stand within the area where the operation was being performed, which meant they were out of women's view. It was my repeated observation that at any one time almost all of the staff stood out of sight of the woman for the majority of her time in the operating theatre. Women also spoke of feeling that the atmosphere around them in the area above the green drape (in which the woman's head and shoulders, her partner, and the anaesthetist were located) was "highly charged". They described there being an air of "tension", "concentration" or "anticipation", as all "waited with baited breath" for the baby. In contrast, the atmosphere on the other side of the green drape (in which the rest of the woman's body and the remainder of the theatre personnel were positioned) was sensed by many women to be one of relaxed bonhomie, and their descriptions closely matched my observations of this being the case.

Dee's statement exemplifies many women's reported feeling of being "somewhere else" while their baby was coming into the world. It also demonstrates the two different micro-climates seemingly created by the green drape. Dee said,

It felt like there was this really brilliant party in full swing going on next door. Lots of relaxed chat...you know, loud, lots of laughing, music. We felt like the nosy neighbours, straining to listen in through the wall or something. I felt a bit jealous 'cause it sounded like a lot of fun. Yeah. I suppose I felt a bit sniffy, 'cos I weren't [sic] invited.

My observational notes, an example of which is provided in Figure 26, also capture how warm and relaxed the atmosphere seemed on the far side of the green drape, in

contrast to how cool and tense it felt on the women's side.

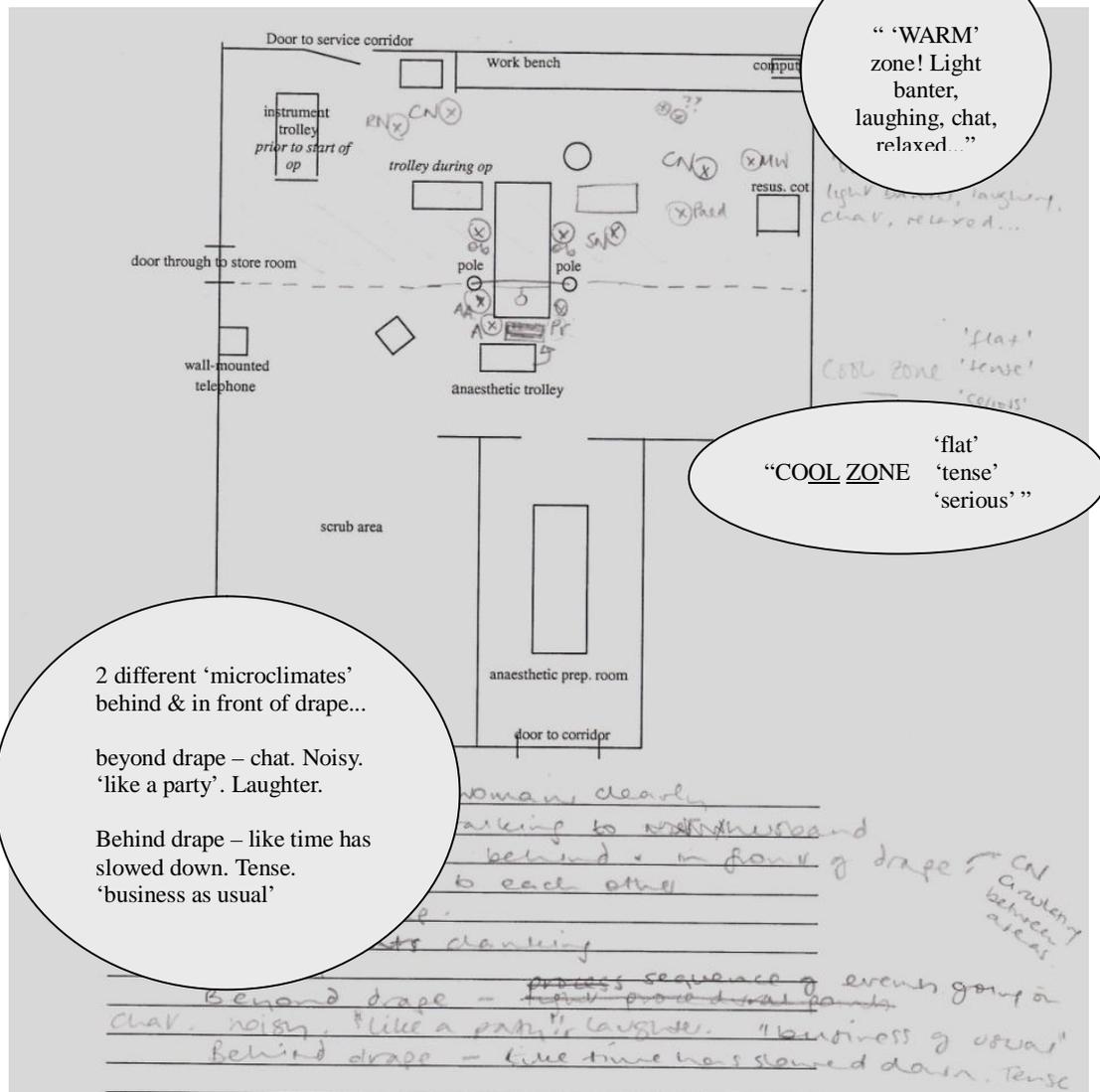


Figure 26. Observational notes: two climatic zones of the operating theatre

Personnel directly involved in the procedure (that is, the primary and assistant obstetric surgeon, and the scrub nurse/s), necessarily had to remain in the lower area while it was underway. Many more staff than this, however, populated the operating theatre during the procedure. All of them, except the anaesthetist and briefly, the anaesthetic technician, also remained in the ‘lower’ zone (out of the woman’s view) for the duration of the procedure, regardless of whether they were directly occupied or not. This was the case in most of the caesarean sections I attended as a non-participant observer, and in every procedure I observed, the attending midwife was among those out of the sight of the woman.

Analysis of observational notes and sketches identified that an average of 11

personnel populated the area beyond the drape during caesarean sections. This number represents those who were present from the beginning to the end of the procedure. In each case I observed, on average, three additional people also came into the operating theatre during the procedure and moved to the ‘lower’ zone. The phrase “person enters” was recorded 45 times during 16 caesarean sections. In some cases, some of these personnel left soon after, but in some, they stayed to the end. Thus, the far end of the operating room was very busy, and at times there were several different conversations happening at once. Like the women articulated, the impression created by the divide was indeed as if there was a party, or “a bit of a social”, as Karen put it, taking place on the other side of the drape. The observational sketch in Figure 27 provides an example of the number of personnel typically present during a scheduled caesarean section apart from the women and her support person.

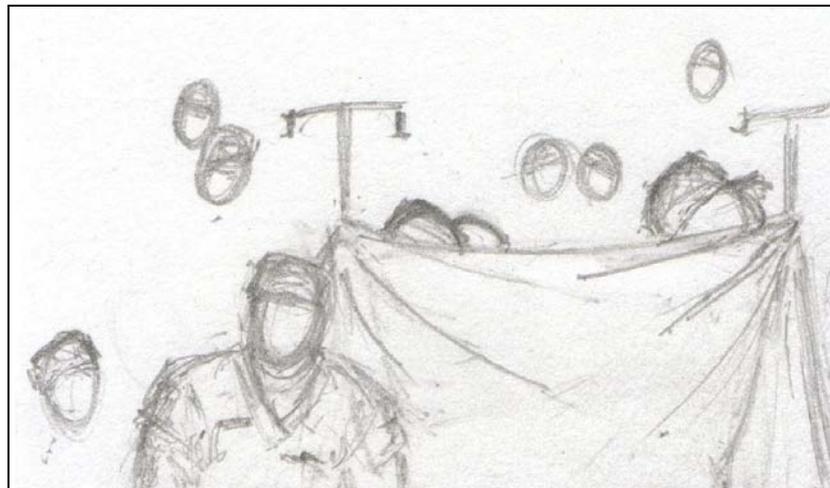


Figure 27. Observational sketch: number of staff ‘beyond the green drape’

Perhaps naturally, staff members that were unoccupied during the procedure were observed to pass this time by chatting in small groups. About one-quarter of the women, when I asked them postnatally about what they remembered about the chatter beyond the screen, could not recollect hearing any. The remainder, however, clearly recalled overhearing staff conversations, and all talked of finding it both comforting and perturbing. Like many of the women who overheard staff chatting, Yvonne was both reassured and upset by it, saying,

On the one hand, I guess they sounded relaxed, and I suppose I interpreted that to mean everything was going fine and I had nothing to worry about. On the other hand though, it was a bit like, you know, “oh well, just another one, nothing special happening here”...But, you know...

my baby was being born! That upset me that they just carried on and talked through it like it was no big deal.

Penny, also like other women, made the assumption herself that the relaxed chatter was a sign that all was well, but wondered why someone didn't use this short period of free time to confirm this and to reassure her. Similarly to others, she said,

Well it all got underway, and I just lost it. Inside, you know? I had thought, "I'll just be calm, just wait..." Well it went quite quiet, and I started shaking, felt panicky, I was absolutely terrified. Terrified. My husband was away in his own little world, trying to see what was going on...the anaesthetist was in and out of my sight... Yeah. I couldn't see a soul. And I could hear all this talking and laughing over there somewhere, and I guessed that I thought that meant it was all right but I also just remember just *willing* someone to think to just come round and just say that yes, it *was* all alright. I think that... (bursts into tears) sorry... (wipes eyes) that might have... I might have felt a bit better if someone had just done, you know...done that. I mean, I was really frightened.

Interviews with doctors, nurses and midwives confirm that, for a time, the woman was indeed forgotten by and did become invisible to them, and that the green drape was instrumental in this. When I asked health care practitioners about their topics of interview in the operating theatre whilst caesarean sections were underway, over three-quarters said they barely spoke at all, or that if they did converse, the topic was case-related. Although it was difficult to discern at times, my observation notes do identify much interview content as work-related, although this was in general terms rather than about the present case. Also recorded, though, are many incidents of social interview. Some examples of interview topics included holiday destinations, relationship news, birthday party plans, recipes and personal health. When this was put to staff, some became quite embarrassed. Nurse Jill, for instance, blushed deeply, put her hand over her mouth and said "No! Oh no. Really? Oh that's not good is it?" Others acknowledged that it probably was the case, however that it was understandable. Nurse Jemma, for example, said, "Yeah, fair cop. Yep. You do lose a bit of perspective, start chit-chatting. I will admit it, at times I do lose sight of what's going on. Well I don't, obviously, but I sort of do. It is a bit 'out of sight out of mind', yeah."

The exception to this was anaesthetists, who identified a key part of their role as listening to, attending to, calming and reassuring women and their partners. Roland, a senior anaesthetist, said "comforting, by being...staying right there beside them is

perhaps the most important part of our role.” Steve, another senior anaesthetist, said he “absolutely [took] a great deal of job satisfaction from being that key support at what I should imagine is an incredibly stressful time.” They attributed their ability to do this in part to the presence of the vertical drape. Sophie, a junior anaesthetist, said that “it sort of cocoons you together with the parents-to-be, it concentrates your focus on them.” Of all the personnel present in the operating theatre during caesarean section, anaesthetists were observed to provide the most attention to women, and as previously reported, featured very positively in every woman’s postnatal interview.

Historically, the practice of draping the body with sterilised sheets during surgery was seemingly adopted to isolate the operation site and reduce the likelihood of environmental wound contamination. The introduction of formal sterile draping of the surgical environment apparently occurred around the same time the link was made between environmental cleanliness and the prevention of infection, in the late 1800s (Reichart and Young 1997). Despite an extensive search of the literature around the history of medicine, surgery and operating room practices and procedures, though, I have been unable to find any information on or rationale for the erection of a drape to form a screen during caesarean sections.

Opinion canvassed from medical and nursing colleagues would suggest that the practice may have been instigated at the time when regional anaesthesia for caesarean section was introduced. During a casual conversation in the operating theatre tearoom with two anaesthetists, an anaesthetic technician, two obstetricians and four theatre nurses, I posed the question, “what is the screen for?” Various responses were tendered, and included “to protect women from the trauma of seeing yourself being operated on”, “to stop patients distracting the staff doing the operation”, “to contain the inevitable spills and splashes, and “for infection control – to stop patients and support people putting their hands down where they shouldn’t.”

Regardless of its purpose, the data strongly indicates that the green drape’s presence throughout women’s caesarean section strongly moderated their experience.

Caesarean section is hospital not women’s business

The fourth identified factor that influenced how women experienced and moved through their experience. Their sense of being wholly displaced by their scheduled

caesarean section was entirely due to the fact that the procedure was regarded by the staff as a surgical procedure that 'belonged' exclusively to the hospital rather than to women. Analysis of contextual data (field notes, observations, health care professional interviews, literature given to women about CS, and clinical guideline documents) demonstrated that caesarean section was considered by the hospital to be a routine surgical procedure that was none of women's business. Typically, women were referred to as 'pre-op', 'post-op', or 'surgical' 'patients' or 'cases', and no role was ascribed to them by the hospital other than one of inactivity, or passivity.

As previously described, once women were scheduled for caesarean section they were excluded from a number of antenatal birth preparation activities. These included, for instance, attending antenatal classes, visiting the area where their baby would be born, and writing a birth plan. Such exclusion alerted and reinforced women's sense of being deposed and made redundant by the caesarean section.

When personnel, specifically midwives, were questioned about the exclusion of women anticipating caesarean sections from these activities, they had very little comment to make. Their responses suggested that neither the preparation of women for caesarean section, nor their participation in it, were matters for consideration. On further exploration, it emerged that this view was based on a belief that women having a caesarean section were not giving birth, that the procedure was no business of women's, and that it was routine, standardised, executed the same way in every case. Midwife Sheree's feeling, for example, was that all women needed to know about and do for caesarean section was "to turn up on time and follow what it says to do on the info sheet."

A widespread lack of recognition for what women might get out of undertaking birth preparation activities, and of why it might be upsetting if they couldn't, was also evident in my interviews with representatives of all staff groups. This sentiment is clearly demonstrated in the excerpt from my interview with Obstetrician Helen (Figure 28); it is characteristic of my interviews with most maternity health professionals on this subject.

S	A number of women have said they'd like to make some sort of plan for their caesarean section Helen. What are your thoughts on that?
H	(Looks confused – frowns, eyes searching) A plan? For a caesarean? What, they tell us how to do it? (shakes head, frowns). I don't understand.
S	No, no... I mean wanting to write down some things, you know, things about it to make it more personal. More, um... special. Like a birth plan.
H	Oh right. Mmm. OK. A birth plan for themselves. Well what would you put in it? What options would there be? (Shrugs shoulders, shakes head).

Figure 28. Excerpt from transcript of interview with Obstetrician Helen

This is what Hayley, a midwife, said about women scheduled for a caesarean section attending antenatal classes:

Well what would be the point? I can't really see what the point would be. I would think if they kept coming it would just rub it in that they weren't having a normal birth anymore. They don't seem to mind dropping out... in fact they'd probably be happy to know they're freeing up a space for someone that needs it (shrugs). Why would you need to learn about birth stuff if you're not giving birth? And, like, what's to learn about having a section that you wouldn't already know? I mean it's pretty much in, lie there, have the op., get stitched up, out, job done? That stuff's all covered in the pre-admission clinic.

Although they were not able to attend birth preparation classes in the same way as women anticipating a natural birth, women scheduled for a caesarean section were given some standardised information about the procedure. This was provided by way of two talks delivered during a pre-admission clinic that women attended in the week prior to their caesarean section. Essentially, the purpose of the clinic seemed to be to ensure that all paperwork (for instance, operation and anaesthetic consent forms, consent for the baby to have various treatments) was completed and signed as necessary, and that all the necessary pre-operative blood tests had been completed, reported and documented.

All women were given the same appointment time, and while each waited to see the midwife, then the doctor and then the anaesthetist, they were addressed collectively, first by an anaesthetist and then by a midwife. The talks were general and didactic in nature, in that the anaesthetist spoke to women about the technical aspects of spinal

and epidural anaesthetic and post-operative pain relief, and the midwife's talk consisted of the content of a booklet that women were also provided with. The content of this booklet (and thus the midwife's talk) presented the 'path' women would be taken down. The physiological implications of the caesarean section procedure were also outlined. Examples of topics covered included how admission, discharge, pain, blood loss, bladder care, wound care, diet and constipation would be managed.

From interviews with women after they had attended the pre-admission clinic, many recalled hoping to, as Donna said, "find out something about how I will feel in (the operating theatre)". As far as the personnel involved were concerned, these two talks were intended to adequately prepare women and their partners for scheduled caesarean section, but although the content did accurately represent what having a caesarean section would be like, women said that the information they were given merely served to reinforce to them that they were not, in any way, part of their baby's birth. Reflecting on the content and delivery of these talks, Yvonne said they were, "Ok. Adequate. Relaxed. Informative, quite interesting", however her impression of the speakers was that they were "a bit off the cuff, done-this-a-million-times-before, sort of thing". She interpreted this to mean that "obviously they see (having a caesarean) as no big deal." Tamsin summed up the underlying message conveyed by the speakers as "we're great, we're very good at this, it will be fine, it will be straightforward, nothing to worry about, we'll take care of everything". Despite this, she said she couldn't help wondering, then, "why I was absolutely shitting myself about it."

My observational data contextualises this impression. For example in my observational notes, I recorded that both the midwife's and the anaesthetist's talks were delivered from the perspective of what women could expect to be 'done to' them, and based on an assumption that women were inert throughout the whole process. The following excerpt from my field notes (Figure 29), made during one such midwife talk, is typical of the reflections I made about this aspect of women's experience:

Midwife very slick, robotic almost. Not really engaging with the women, although they are hanging off her every word. Clearly done this a million times before. Speaking at pace, quite rushed. Reading from booklet, some ad lib-ing/anecdotes but very 'practised'. There's a lot of telling women what *will* occur, what they *must* / *must not* do... The inference is that women are passive in all this and expected to be obedient, 'seen and not heard'. Midwife now saying women will not be told what time their caesarean will be because planned sections happen around emergencies. I know what she means but it sounds like "in case there's any doubt left in your mind, you're not in the least bit important". Like she's making sure they know they come last, almost putting them in their place. It sounded a bit like they could very well be waiting for days, but they're not to ask questions – that is how it is!!! A bit belittling, like "you are the least of our problems so don't even bother asking us about it, we'll get to you when we get to you".

Figure 29. Field note: reflection on pre-admission clinic midwife talk

Although women were invited to ask questions after each talk, my observation on the occasions I attended was that it was somewhat of a token gesture, and in fact no-one did ask any questions. When I explored this with women in interview, many did indeed volunteer that although questions were invited, the invitation did not come across as genuine. Many women also said they felt that they had wanted to ask questions of an emotional nature but had withheld either because if the midwife hadn't covered it, it couldn't be relevant or because it was too uncomfortable to ask personally meaningful questions in a group. For Rose, like, many, the talk left her with a sense that she ought not to feel the way she did about having a caesarean section. She said,

I just felt stupid for even thinking about asking what I had wanted to ask after she finished. Like, well about how you're supposed to cope with it in there. When obviously I'm making too big a thing of it. I should just deal with it. They seemed to be saying it's just a little routine, everyday operation, leave it to us, you'll be fine, no big deal, so... (shrugs)

Women spoke of storing their questions until they had their one-to-one consultations, but unfortunately for most, the opportunity just never arose because the focus of the appointments was the physical surveillance of the woman and fetus, and the completion of necessary paperwork. Interestingly, midwives' view of why women didn't tend to ask questions was that the information provided was adequate. When I remarked to midwife Jill that no-one seemed to have any queries after the talks, she said, "Well we're pretty thorough, we do make sure we cover everything. We just do

too good a job, obviously (laughs).”

To further inform how the hospital’s view of scheduled caesarean section might moderate women’s experience of it, I reviewed all hospital documents related to the procedure. This data set included clinical practice guidelines and protocols, departmental documentation (for example pre-procedure checklists, post-procedure care pathways) and patient information material. Without exception, all communiqués referred to a caesarean section as an operation, and to women as patients; nowhere did they refer to the procedure as a birth or to women as mothers. The clinical practice guideline for the care of women following caesarean section that was current at the time of this study reflects this view (Figure 30).

IMMEDIATE CARE

- Check patient’s identity. Check doctor’s orders with recovery room staff.
- Check all dressings, drains, intravenous therapy and observations before leaving recovery room.
- Ensure dentures, medical records and x-rays are returned to the ward.
- Escort patient from Theatre.
- Adequately cover patient.
- Transfer patient from the trolley to the bed with the assistance of slide boards and the help of the orderly and another midwife.
- Remove canvas from underneath patient.
- Position the patient according to patient’s comfort and operation performed.
- Report to Shift Coordinator and record all details of patient’s return.
- Ensure patient’s bell is accessible and working.

SUBSEQUENT CARE

- Continue observations of vital signs:
 - Temperature, pulse, blood pressure
 - Wound, wound drainage
 - Intravenous fluids
 - Vaginal loss
 - Urinary output
- Give analgesia as soon as required, as ordered by doctor.
- When observations are satisfactory, sponge patient and change into own night attire and reposition.
- Encourage patient to commence deep breathing, coughing and leg exercises.

ROUTINE OBSERVATIONS

Colour, pulse, blood pressure, respiration rate, wound soakage, vaginal loss, intravenous rate and urinary output:

- ½ hourly for 2 hours
- hourly for 2 hours
- 2 hourly for 2 hours
- 4 hourly until condition is satisfactory or more frequently as deemed necessary

Report any abnormalities to medical officer.

DIET**AIMS:**

- To maintain the woman's hydration and nutritional needs post caesarean section
- To assist in the prevention of postoperative ileus

RECOMMENDED REGIMEN:

Generally, there is no reason to wait for the passage of flatus or a bowel action before initiating full diet.

Unless otherwise ordered by the surgeon or anaesthetist, the following regimen should usually be followed.

1. Intravenous fluids to be maintained as requested by the anaesthetist or surgeon.
2. Encourage a fluid intake of at least 2 litres per day.
3. Oral intake
 - a) Fluids may be commenced as requested by the woman.
 - b) Full diet may be commenced as requested by the woman.
4. Women with a complicated caesarean section (e.g. bowel surgery involved) may be excluded from the above regimen at the discretion of the doctor.

Figure 30. Clinical Guideline No. 7.7 'Caesarean Section: Post-Operative Care' (Women's & Children's Health Service 2001).

This prevailing assumption held by the hospital that scheduled caesarean section was its exclusive problem was the final elemental factor that moderated how women experienced having a baby in this way. In the following section, I will report three women's experiences of needing and having a scheduled caesarean section that, because of the absence of one of the preceding moderating factors, were entirely different to that already described.

Ginny and Pauline

Although Ginny's and Pauline's stories are quite different, they are reported here together because the way in which neither fit, and therefore support, the emergent

Grounded Theory is similar.

Ginny was a 41 year old woman having her first baby, while Pauline was aged 28, and was having her second. As with the majority of the participants, I approached both women through the caesarean section pre-admission clinic, and then interviewed them individually within the ensuing 48 hours of them consenting to participate. Ginny was scheduled for a caesarean section because her baby was diagnosed as being in a non-cephalic position at 38 weeks gestation. The rationale for Pauline's was documented at her 36-week visit with an obstetrician as "previous complicated delivery, subsequent perineum reconstruction".

It was clear from the outset that Ginny's and Pauline's experience of scheduled caesarean was likely to eventuate very differently to the other women's when, opposite to all of the other participants in the current study, both of their demeanours were upbeat, relaxed and excited when I met with them. Also, very early on in their first (antenatal) interviews, each identified how "pleased" and "relieved" they were that a scheduled caesarean section had become necessary.

It transpired that both women, at their hospital booking visit, had sought to book a caesarean section but had been refused. They had each been advised that the facility would not schedule one without a compelling medical reason which, at that point, neither were deemed to have. Both Ginny and Pauline said they had been rather surprised about this, and each spoke extensively about their belief that it should be women's right to choose how they wished to "deliver". Ginny went on to say that if she could have "gone private" she would have, but that because she had not been contributing to her health insurance fund long enough, it wasn't an option. Her preference for private obstetric/maternity care was based on her feeling that she was,

pretty sure if I'd gone private, I could have just asked for a caesar [sic] and it would have been, you know the obstetrician would have just got the diary out there and then and said "which date" sort of thing. They trust that the mother knows what's best for her. So if it's OK there, and they are top experts, it makes you wonder why it is that it's not OK everywhere.

While Ginny said she "would just prefer a c-section", Pauline had a deep fear of delivering vaginally as a result of her previous experience. Not having her wish to have a scheduled caesarean section granted "was a real downer", and she said several

times that she had been “really unhappy”, “really flat” and “really worried” about the prospect of a natural birth. The birth of her first baby had been nine years earlier. In her own words, Pauline said she had been “young, single and very naive”. She recalled her labour as “long, frightening and very traumatic, both physically and mentally”. Pauline told me she had been in hospital for “about ten days” after the birth recovering from an extensive perineal tear that had to be repaired under general anaesthetic, and had subsequently had further reparative surgery over the following two years. Although she had explained this to the doctor at her initial booking visit, it was at that time deemed an insufficient reason to book a caesarean section. The decision to schedule one at a later appointment was as a result of a comprehensive review of Pauline’s previous birth notes by a different doctor.

For both Ginny and Pauline, scheduled caesarean section represented the “best”, “safest”, “most sensible” way to have a baby, and they talked of the procedure as “calm”, “controlled” and “civilised”. Comparatively, both women said, natural birth was an unnecessary effort that involved suffering and indignity, and had an unacceptably high potential for going wrong, or “pear-shaped”. They also both expressed a firm belief that it should be maternity care professionals, not women, who took responsibility for childbirth. Pauline said, “I did it myself last time and it was a disaster. I learnt my lesson - leave it to the experts”. Similarly, Ginny said “look I’m doing this for the first and probably only time. They’ve had experience of delivering hundreds of babies, probably thousands some of them. I know who my money would be on to get me through it better”.

On further exploration of the basis for each woman’s beliefs about vaginal birth and caesarean section, Pauline linked her views to her previous experience of giving birth vaginally. Ginny, though, couldn’t really pinpoint why she felt this way. She did offer that “it may have had something to do with the fact that all (her) friends think that way too”. She went on to say “I would never choose vaginal birth” and that she “didn’t know anyone who would...I just think it’s too risky.” Ginny also disclosed that she had fielded “a fair amount of teasing” among her peers because she *hadn’t* got a caesarean section scheduled. It became evident through the analysis of these women’s data that what both thought scheduled caesarean section would give them over natural birth was a controlled, safe birth experience. Ginny, for example, wanted to “guarantee, as far as possible, a straightforward birth...no nasty surprises, no panic

stations.” Pauline wished to avoid a “long, drawn out labour” from which she might “very possibly end up damaged, exhausted and not able to care for the baby.” Each said their first priority was to be in a fit and well state to begin mothering immediately after their baby’s birth, which they perceived they would be following a scheduled caesarean.

The fact that these two women did not covet a natural birth as the other 25 women did meant that when a caesarean section was scheduled for them they were, respectively, “absolutely rapt, over the moon” (Ginny) and “delighted, so relieved” (Pauline). In no way did either feel robbed by the need for it as the other women did. Unlike the others, these two women had no need to do the regrouping work of trying to make it feel real. Nor did they feel they were travelling a new path blindly, they already felt very comfortable with what a scheduled caesarean section meant (a safe, controlled birth) and what their role was (to surrender all responsibility and control to the surgical team).

Unlike the women for whom scheduled caesarean section was unwanted and unwelcome, both Ginny and Pauline conveyed to me that once the decision had been made and their caesarean sections had been scheduled, each felt they could relax and really enjoy the remainder of their pregnancy. As the other women had, these two also spoke about feeling the responsibility of their baby’s birth being completely lifted, however as far as they were concerned, this was a positive implication of needing a caesarean section, not as a negative one as it was for the others. Pauline and Ginny both said they had felt immense pressure to “perform well” when they had been anticipating giving birth naturally, and Ginny particularly had found being encouraged to focus on and prepare for it very challenging and frustrating.

While she recognised that giving birth naturally would entail “serious effort” and had “thought about it a bit”, Ginny said, she considered investing any more time than that as “a waste” and “futile”. Unlike the other women, Ginny made no reference to drawing on personal qualities as a way of staying in command of labour and birth: her view was that labour and birth had “got its own agenda”, and that it was wayward and untameable. The thought of making a birth plan had been to her, she said, “absolutely ridiculous”. She went on to say that “It really started to annoy me when they kept on at me about a birth plan. I didn’t want to do a birth plan and all that.

What's the point? You can't plan the un-f*****g-plannable".

Pauline, too, said she was "a bit sceptical about (making a birth plan) because...nature's got its own idea of what'll happen. The whole thing is booby-trapped. I know. It's impossible to predict." She analogised it as like being on a fairground ride. She said,

I'd be an idiot if I thought I could say, "oh, this is how it'll be" cos you're not in control are you? It's like being on a rollercoaster...you just get moved along. You're at it's mercy. And you have just gotta [sic] strap in, hang on tight as you can, and hope it all works like it's supposed to and you don't fall off.

Pauline's "only plan" for a natural birth had been, she said, "to have no plan."

To the other women, giving birth naturally promised an unparalleled transformational experience that was not to be missed, as well as an infant. Natural birth did not hold the same meaning for Pauline and Ginny, though, and for each, the baby was their only desire. Consequently, neither felt they had lost anything, as they had both long held the view that, as Pauline said "it's all about the prize, the baby" and as Ginny said, "it's about the outcome, not the process."

When the day came for each to have their scheduled caesarean section both were observed to be, and confirmed later that they were, focused, chatty and excited. Having said this, like the women who did not welcome their caesarean section, Pauline and Ginny also experienced feeling as if they were off everyone's radar during the procedure, but they each interpreted this positively to mean the operating theatre personnel were solely focused on their jobs. Although each said in their second interview that they had felt some nervousness and apprehension about the procedure, their complete faith and trust in the staff caring for them meant that neither experienced the high levels of fear and anxiety that the other women had. It was evident in both Ginny's and Pauline's postnatal data that each had been "happy to just let the staff do their job", and maintain her focus on the time when she would begin to care for her baby.

Both Ginny and Pauline suffered complications that necessitated medical intervention following their scheduled caesarean sections. Pauline had a large postpartum haemorrhage following her return to the postnatal ward and was

transferred to the high dependency unit for 24 hours. Both women developed wound infections and received antibiotic therapy. Ginny also developed a wound breakdown that necessitated a return to theatre six days after her discharge home. Despite being normal, well and born at term, both babies also experienced health difficulties soon after birth. Pauline's son developed respiratory distress in the operating theatre and spent his first nine hours in an incubator in the special care baby unit. Ginny's daughter did not feed well in the day following her birth and was unable to maintain an optimal blood sugar level. This meant the baby received prescribed nutritional formula in addition to breast milk for about 36 hours. To both women though, when they were recounting their stories at around three months post-natal, these complications constituted mere and unfortunate setbacks that were unimportant in the context of having become a mother. Both maintained their view that scheduled caesarean section was "the way to go".

Michelle

Michelle was a 30 year old woman who telephoned me in the recruitment phase of the study. At the time of her call, Michelle was 18 weeks pregnant with her third child. She had seen the poster advertising this study during her booking appointment in the hospital's antenatal clinic and had a very strong wish to participate. As Michelle disclosed her childbearing background and her plan for this birth to me, it became apparent that she did not meet the inclusion criteria. Following discussion with one of my supervisors, however, it was agreed that because of her strong desire to contribute to the investigation, and the very unusual nature of her plan for this baby's birth, Michelle's wish to be included would be upheld. She was included in the current study as a negative case.

Despite intending and hoping to give birth naturally on both occasions, Michelle's previous two pregnancies had both culminated in unscheduled caesarean sections for emergent reasons during labour. Michelle described her first caesarean section as "devastating" for the whole family; she developed post-traumatic stress and postnatal depression in the ensuing months. The second caesarean section was, Michelle said, "much, much better" in that she "knew it was necessary". Although Michelle said her second caesarean section was "as good as a caesarean could be", she still described it as less fulfilling than she imagined a natural birth would have been. Similarly to the 25 women in this study, Michelle said her caesarean sections had been unwanted,

unexpected, had 'stolen' many things from her and had effectively "pushed her aside".

According to Michelle, both experiences of "dealing with the unexpected" had cumulatively taken their toll on her emotionally. Soon after her second unscheduled caesarean section, she said she made the decision that she would not pursue a natural birth again. Having made this decision, Michelle and her husband Matthew planned to conceive their third baby. Once she actually fell pregnant, however, Michelle's said her joy was marred by sadness at the thought of having a caesarean section she felt she had to have but didn't really want. Michelle briefly revisited her decision not to pursue a natural birth, but ultimately she came to the same conclusion as she had pre-pregnancy. Michelle maintained her decision to have a scheduled caesarean section, primarily on the basis that she was certain she would not, with three children, be able to muster the emotional energy necessary to deal with it if she tried to give birth naturally again and was unable to.

This turmoil meant that during her early pregnancy, Michelle had been "consumed" by anxiety, fear and tension. Although she had since resigned herself to having a scheduled caesarean section, she said she was not looking forward to it one bit. Similarly to the 25 women in the study, Michelle spoke of feeling profoundly sad at the prospect of what she understood to be a "standard, routine, clinical, nothing special" procedure. Like them, she wanted her baby's birth to be a natural, joyful event. Differently to the other women, though, the decision for a scheduled caesarean section was Michelle's. This meant that although she felt a sense of loss and disappointment at being unable to birth naturally, Michelle didn't have the same sense of feeling so robbed, violated and shocked as the other women, and neither did she have to do the work of trying to make it feel real that they had to. In other ways, though, Michelle's experience was just like the other women's. At her first hospital antenatal appointment, for example, Michelle said she got the distinct impression that she was somewhat of a "nobody" in the eyes of the hospital. Her suspicion that a scheduled caesarean section would indeed be a "cold, routine affair", that was the hospital's business not hers, was also confirmed at that time.

Following this experience, Michelle decided she would not accept this fate, and she sought to make her baby's birth more fulfilling. This involved seeking support from

the hospital to have a very “different type of caesarean section” than she had previously experienced and that was currently routine. At some point following her second baby’s birth, Michelle had become a member of a community support group run by and for women who were dealing with giving birth by caesarean section. Through this group, she became aware of a woman in another Australian state who had negotiated with her obstetrician to make her caesarean section a more meaningful experience. The woman’s solution to improving her experience of the procedure was to be part of the operating team and retrieve her baby from her body once the surgeon has opened her abdomen and uterus - a radical and potentially revolutionary concept at the time. This woman’s reasons for wanting to assist in her baby’s caesarean section birth - to feel wholly engaged and present in the experience - resonated strongly with Michelle. She said that immediately she heard it she knew this was something she would like to do. It seemed to her that in this way, a scheduled caesarean section *could* be a deeply fulfilling birth experience, whereas prior to hearing the story, it “hadn’t looked as if it could be at all”.

At first, Michelle dismissed the idea, deeming it “so totally way out” that she couldn’t imagine “the hospital going for it”. Soon after her booking appointment, though, when she felt that her baby’s birth threatened to be “another soulless experience”, she made the decision to pursue what later became known as a ‘maternally-assisted’ scheduled caesarean section. It was soon after she had made this decision that Michelle telephoned me wishing to be part of the current study. At this point, almost half of Michelle’s pregnancy had already passed, and like the other women, she felt a sense of urgency to get her plans in place as the date for her caesarean section - her ‘D-day’ - came ever closer. Only once things were “sorted”, as she termed it, could she “relax, enjoy being pregnant and get excited about the baby.”

Michelle’s involvement in her own surgery involved her ‘scrubbing’ and donning surgical gloves before she lay on the operating table. The surgeon would perform the operation, deliver the baby’s head, and then prompt Michelle to reach down for her baby. She would then bring her baby out from her body and bring him up to her chest. Differently to the other women’s experience, the green drape would not be hung during Michelle’s caesarean section. Neither would the baby go to a neonatologist or a midwife. Additionally, Michelle arranged to have a second

midwife with her in the operating room specifically to ensure that her baby remained with her through the completion of the surgery and the immediate recovery period.

After “pitching the idea” to the hospital’s medical director and other senior clinicians the hospital did, after further discussion, support Michelle to have a maternally-assisted caesarean section that both prioritised the mother-baby relationship and fulfilled the needs of the staff and the organisation. There were many positive repercussions from Michelle’s caesarean section, and these are detailed in the conclusion of this thesis.

When I interviewed Michelle at 13 weeks postnatal she spoke enthusiastically and at length about her caesarean section and what a “great experience it was”. She was, she said, “still on a massive high” from it, and felt as if she was “walking on air”. She talked animatedly about it, and in stark contrast to the other women in the study, said there was “no doubt in her mind” that she “gave birth that day”. In discussing what it was about her caesarean section that made it such a good experience for her, she said there was no doubt in her mind that “having a job to do, being involved” was what made the difference. Unlike the other women in the current study, having a clearly defined role to play in the operating theatre meant that Michelle did not have to do the emotional work of discovering her role and purpose during the procedure that the other women did. Differently to the other women, Michelle was very visible, the focus of everyone’s attention and on everyone’s radar on the day of her caesarean section. As a result, unlike them, she had no need to strive to be included as either a participant in her baby’s birth or as her baby’s mother. My non-participant observations also show that she was acknowledged and included in what was going on during her time on the operating room, and that she engaged with her caregivers throughout the procedure. Michelle evaluated her baby’s birth as having been,

like all births should be, where everyone who’s involved recognises that something really special’s happening. Everyone in that room realising they’re honoured to be part of, well it’s a miracle really innit [sic]? They’re witnessing a new life beginning. It’s a privilege, not a right.

Another strong contributor to Michelle’s experience was the absence of the vertical surgical drape during her caesarean section. Unlike the other women, Michelle’s body (and by extension the operating room) was not artificially divided into two zones, she was visible as a whole woman to all of the caregivers in the room, and in

turn so were they to her. An observational sketch made of Michelle in the operating room, just after her baby had been born, is provided in Figure 31.

When Michelle spoke postnatally about her caesarean section, she did so with joy, confidence and pride. She said that not only did she feel deeply satisfied and fulfilled by her experience, but that it had “healed the whole family”. It was as if, she said, the whole family had been “sprinkled with magic dust.” Perhaps most notably, in contrast to the other women whose experience had left them wanting, and who at 10 to 14 weeks postnatal felt as if they were just treading water , Michelle talked of having “just moved on” from the caesarean section, to “being a fully there, fully focused mum and wife”.

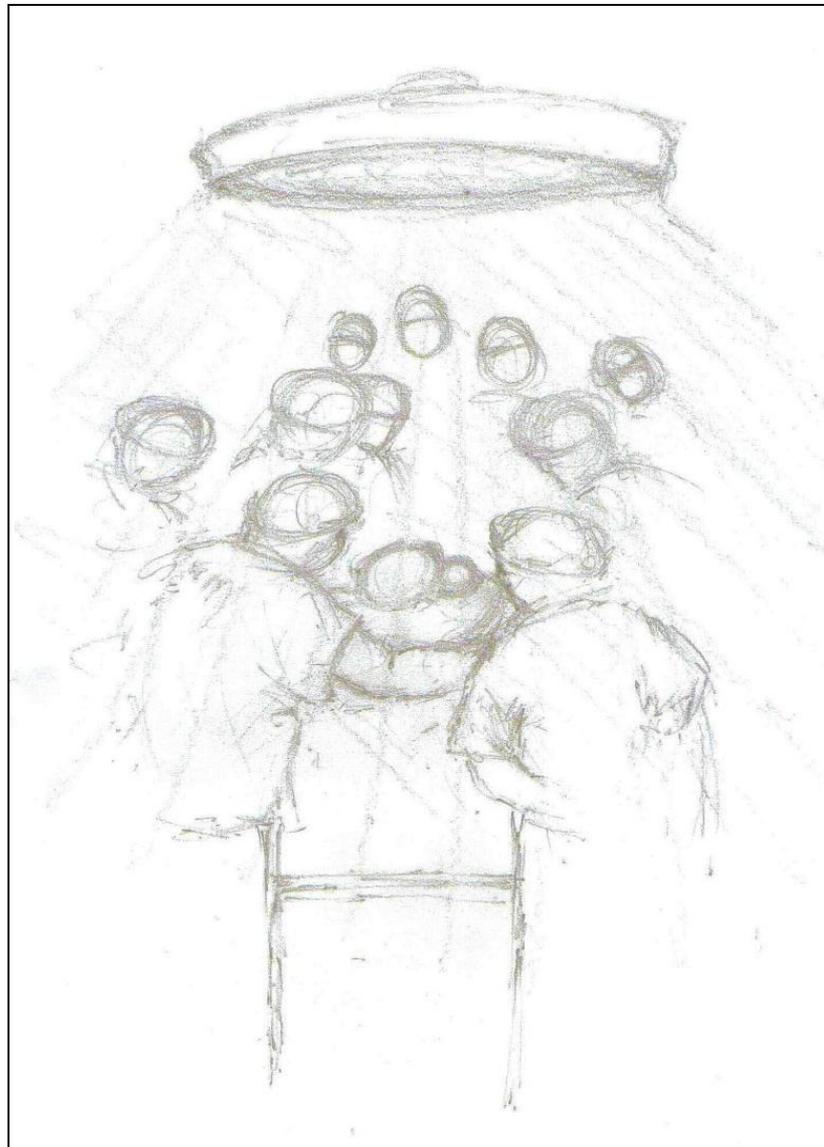


Figure 31. Observational sketch: Michelle in the operating theatre

Summary

In this Chapter, four factors that emerged from the data as moderators of women's experience of scheduled caesarean section have been described. Three negative cases have also been presented, and serve to confirm that scheduled caesarean section effectively makes women redundant as birthing mothers. This concludes my report of the findings of the current study. In the following chapter, I will discuss the findings in the context of existing scholarly literature and theory.

Chapter 7

Disintegrated Expectations and a New Reality

Introduction

The findings presented in the previous three chapters provide the reader with a unique insight into how 28 Australian women experienced and processed a scheduled caesarean section. This research revealed that, far from being celebratory and joyful, the birth event of the 25 women who wanted to give birth naturally left them lamenting a range of devastated expectations. When these 25 women began on their childbearing journey they did so with complete confidence in the natural birth process, with buoyancy, joy and excitement about what lay ahead, and with optimism about their ability to meet the challenges to come. By 10 to 14 weeks postnatal, however, they were deflated, bewildered, haunted and greatly distracted by their childbearing experience and the many unanswered questions that remained. These findings are now considered in the context of previous published research and theory, and the new insights that this research offers are located in the body of work concerned with women's expectations and experiences of childbirth. This chapter is presented in two parts.

Part 1 discusses the disintegration of women's childbirth expectations. The need for an unwanted and unforeseen caesarean section has been framed as a **redundancy** that entailed complex change and relocated women into an unfamiliar landscape. In this 'new reality', women's expectations were displaced and they were unable to fulfil their role as a childbearing woman. It is also identified that women incurred a number of personal losses as a result of this change and that, in turn, these losses engendered a sense of grief and traumatic stress. To follow, the maternity service's philosophy of birth and caesarean section contribution to women's sense of being dismissed is examined, after which the potential significance of women being unable to accomplish their birth expectations is explored.

In Part 2, the women's efforts to accommodate their new reality are discussed. The regrouping processes that women undertook in the antenatal, intrapartum (intraoperative) and postnatal periods are recognised as their attempt to

‘psychosocially transition’ from all that was comfortable and familiar to a new, strange and undesirable situation. Reasons for why women were unable to complete this psychosocial transition by the time their baby arrived are presented. Finally the potential implications of not being able to ‘move on’ from the birth experience are explored and discussed in relation to scholarship.

Part 1: The disintegration of birth expectations

The first part of this discussion is concerned with the psychosocially shattering experience of becoming redundant as a birthing woman. Twenty-five of the 28 participants in this study entered into their pregnancy with a long-held expectation of a spontaneous uncomplicated labour and an intervention-free birth. In relation to this primary expectation, the women also anticipated they would ‘own’ their birth experience, be cared for holistically, would participate in certain rites of pregnancy and birthing, and that they would be the central focus of their carers’ attention. In addition women believed that they would take up their mothering role from the moment their baby arrived and that they would feel strongly maternal towards their baby. Women also assumed their carers’ view of childbearing would match their own.

As previously mentioned in Chapter 1, the scientific literature clearly indicates that holding specific childbirth expectations as those outlined above is not unique to the women in this study. Early work by Brewin and Bradley (1982) reported women to hold expectations about whether they or the staff caring for them would have control over their labour while Knight and Thirkettle (1987) found women expected that birth would not be unpleasant. Morcos, Snart and Harley (1989) recorded women’s childbirth expectations to include knowing who will attend the birth and that caregivers will share a similar childbirth philosophy. Women in Morcos and colleagues’ study also expected to be afforded choice, to remain together with their baby after birth and that they would have an opportunity to review the birth experience postnatally with a caregiver who was present at the birth. Adding to this growing body of knowledge was the early nineties work of Beaton and Gupton’s (1990). These researchers reported several extremely negative expectations of childbirth, particularly in relation to pain and their own ability to cope. They also, however, identified an expectation that these would be cancelled out by “an intense emotional high” and “happiness, love and relief” immediately after the birth (p. 135).

Dichotomous expectations of pain and fulfilment in relation to labour were also identified by Fridh and Gaston-Johansson (1990), Green, Coupland and Kitzinger (1990) and Salmon, Miller and Drew (Salmon, Miller et al. 1990). Like some of Brewin and Bradley's (1982) participants two decades earlier, women in later studies also expected to have control of their birth (Gibbins and Thomson 2001; Kao, Gau et al. 2004; Fenwick, Hauck et al. 2005). In Gibbins and Thomson's work (2001, p.302), having control was identified specifically to mean taking "an active part" in the experience. Expectations of retention of control, of support and of participation in the process have also been well articulated by others (Gévry and Goulet 1994; de Oliveira, Riesco et al. 2002; Oweis and Abushaikha 2004; Hauck, Fenwick et al. 2007; Darvill, Skirton et al. 2008). Threaded throughout the literature, though, is one key underlying childbirth expectation. As was the case for the participants in this study, women around the world have been reported to predominantly expect that birth will be spontaneous, vaginal and a positive life experience.

The disappointment and distress the women in this study experienced was a direct consequence of no longer being able to fulfil any of their often long-held and cherished childbirth expectations. Positioning the disintegration of expectations as personal losses helps explain the women's reactions.

The aetiology of perceived loss

Crisp, Potter, Perry and Taylor (2005) assert that there are two forms of loss, which they identify as "actual" and "perceived" (p. 559). When loss is referred to as actual, it is generally in the context of the death of another, for example a person or a pet. Perceived loss, on the other hand, is said to be felt when that which is lost is intangible, invisible and meaningless to others, as might occur when personal hopes or expectations die. According to psychiatrist Colin Murray Parkes (1993, p.102), when radical change is experienced, the opportunity to fulfil our expectations die, and what we experience is the perceived loss of our entire "assumptive world".

Parkes introduced the concept of the assumptive world in the early 1970s, and described it as including "our expectations of the future, our plans and our prejudices" (1971, p.102). Building on this early work by Parkes, others went on to review and clarify the concept of the assumptive world. Janoff-Bulman (1992), for instance, interpreted the phenomenon as one's value belief set, and theorised that

when constancy of beliefs is disrupted - such as when enforced change occurs - ideals of meaningfulness and self-worth are lost, or shattered. Landsman (1997) acknowledged Parkes' explanation of the assumptive world and posited its loss as "a crisis of meaning". Kauffman (2002) defined the assumptive world slightly differently to Parkes and Landsman, suggesting it consists of "beliefs that ground, secure or orient people, that give a sense of reality, meaning or purpose" (2002, pp.1-2). Like Janoff-Bulman (1992), Beder (2004) also clarified that when expectations are challenged or shattered by change, the security of one's beliefs is aborted. When these theories are applied to the current study, it becomes clear how women felt the need for a caesarean section robbed them not only of the potential to fulfil their childbirth expectations, but of their sense of self. What follows is a discussion of the specific perceived losses incurred by the women in this study within the context of the wider maternity literature.

Loss of the opportunity to give birth naturally

As briefly noted earlier, the expectation of a natural birth expressed by the women in this study reflects the findings of other research investigating women's expectations around mode of birth. These participants expectation that they would give birth naturally also confirms mounting evidence that most women would prefer a spontaneous vaginal birth over a caesarean section, despite continued media and medical debate to the contrary. In their review of ten papers on the subject of 'maternal request' caesarean section published between 1993 and 1999, Gamble and colleagues (2001) concluded that the proportion of women wishing a caesarean section in the absence of previous or current obstetric complications was less than one per cent.

A subsequent review of 17 similarly-themed research studies published between 2000 and 2005 found that even in the presence of previous or current obstetric complications, caesarean section was the preferred birth mode for no more than 13.4 per cent of women internationally (McCourt, Weaver et al. 2007). Cross culturally work continues to demonstrate that this is the case. For example, of 317 Ghanaian women 93% stated they favoured vaginal birth in most obstetric circumstances, as opposed to just 3.5% who preferred caesarean section (Adageba, Danso et al. 2008). In Australia, work detailing women's childbirth expectations is fairly limited, however similar to the women in this study, participants in Fenwick and associates'

(2005) large qualitative investigation also identified natural birth as a priority expectation.

While some investigatory work has been undertaken on how women feel antenatally about not having the opportunity to have a natural birth, for the most part the research is exclusively concerned with postnatal evaluation of the childbirth experience. In Churchill, Savage and Francome's survey of UK women's postnatal perceptions of caesarean section, many women reported the experience of 'suffering' as a result of not being about the birth naturally. The data in Churchill and associates study closely reflects that presented in this thesis, with one woman whose caesarean section was scheduled in pregnancy quoted as suffering "emotionally because I wanted to do it naturally by myself..." (2006, p.141).

Preference for natural birth was also inferred in Tatar, Günalp, Somunoğlu and Demiroğlu's (2000) research investigating 171 Turkish women's perceptions of their caesarean section. These researchers found that 62% of participants experienced fear, guilt, anger and a sense of failure in relation to having had the procedure unexpectedly. In addition, 27% of Tatar and associates' sample referred specifically to feeling sorrowful about losing the chance to give birth vaginally. Expectation of, or preference for natural birth, was not explicitly identified in Rijnders and associates' (2008) study of 1039 Dutch women's recall of birth as a positive or negative event. A statistically significant association, however, between women having had a caesarean section and being very unhappy with the birth suggests it was the case.

Loss of role and responsibility for birth

According to Luyben and Fleming (2005), being able to bear the responsibility of childbearing is of fundamental importance to pregnant women. Unfortunately, as soon as the decision was made that a caesarean section would be scheduled, the women in the current study reported that without exception, care and communications from that point on were underpinned by a presumption that the system was now responsible for the baby's birth. Furthermore, what was also apparent from the health professionals' data was a prevailing view among maternity carers that women would be accepting, grateful and would (or should) not be upset. In reality though, the need for a caesarean section created an inner tug-of-war for the

women as they struggled to find a way to retain a sense of responsibility for and control over their experience in the face of this comprehensive ‘takeover’ by the hospital.

Although loss of control during childbearing has been documented previously, this has only been in relation to its role in women’s postnatal satisfaction with their birth. Loss of control in the antenatal period has yet to be reported in the literature. In addition, the work on this subject has thus far been predominantly concerned with natural birth; no research seems to exist concerning loss of control in the context of scheduled caesarean section. What is apparent, though, is that control, particularly in relation to decision-making, is of importance to childbearing women cross-culturally. Simkin (1991), in her exploration of the long-term recollections and impact of UK women’s birth experience, found the retention of control to be an important factor for women’s childbirth satisfaction. Women who said they were highly satisfied with their birth experience, both in the days after the birth and 16-22 years later, recalled feeling in command regardless of whether the birth eventuated as they had anticipated or wanted. These women directly attributed their ongoing high self-esteem and self-confidence to their positive experience of childbirth. In comparison women in Simkin’s study who were originally less satisfied and continued to be so, remembered having little or no say during their childbearing experience.

Similarly, Fowles (1998), who explored American women’s perceptions of their birth experience at nine to 14 weeks postnatal reported that those who had felt unable to exercise control during labour evaluated their experience as frustrating and unpleasant. An association between American women feeling in control of and being satisfied with their natural childbirth experience was also confirmed some years later by Goodman, Mackey and Tavakoli (2004).

In a paper published around the same time as that of Fowles’ (1998), British team Lavender, Walkinshaw and Walton (1999) reported over 500 UK women’s views of the most important aspects of their labour and birth at two days postnatal. Although control was mentioned by many, this was in the context of behavioural self-control rather than control over the experience. Almost one-third of Lavender and colleagues’ participants did, however, cite being involved in care-related “decision making” as being important, and described feeling angry when their autonomy was

not enabled (p.48). Likewise an inability to retain personal power and control, as well as not being informed, also featured in the experience of participants in US researchers Mazingo and associates' (2002) qualitative investigation into the aetiology of women's childbirth-related anger.

By the end of the 1990s, a sense of control had been well established in the literature as a major contributor to a woman's perception of a positive childbirth experience. It was on this basis that Green and Baston, in their prospective study of the concepts, correlates and consequences of control in English women's birth experiences, sought to "advance an understanding" of the phenomenon. Unfortunately, because this study was concerned with the experience of labour, data from 116 women booked for caesarean section were excluded. This in itself makes a powerful statement about the invisibility of women who give birth in this way. Of the remaining 1163 participants, 40% reported not feeling in control of what staff were doing in the intrapartum period, and for 11% of the sample, this was specifically related to "non-emergency decision-making" (2003, p.236).

In work investigating factors contributing to Scandinavian (Swedish) women's negative experience of childbirth, all 2811 respondents noted that "involvement in decision-making" was implicated in how they felt about their birth experience (Waldenström, Hildingsson et al. 2004p.23). As in previous studies, greater involvement was found to equate to greater satisfaction. Maintaining control during childbirth has also been found to feature as important for Canadian and Jordanian women (Bryanton, Gagnon et al. 2008; Oweis 2009), and seems just as important for Australian childbearing women too. The majority of participants in Schneider's (2002) grounded theory study of women's first pregnancy experiences, for example, mentioned involvement in decision-making as a need. Likewise, loss of control was reported to be a characteristic of a 'diminishing' birth environment in Bayes, Fenwick and Hauck's qualitative analysis of women's short accounts of labour and birth (2008). When the experience of the women in the current study is considered in the light of the convergent literature, it is little wonder that they felt a sense of loss once their role and ability to control their experience was usurped.

Loss of joy, confidence and security

The moment the decision to schedule a caesarean section was made, the women in

this study reported that their excitement and joy evaporated or 'was stolen' from them. The decision instead heralded in a sense of disappointment, uncertainty, worry and fear. Disappointment has, as discussed previously, been reported as a feature of childbearing in women whose expectations are unmet by their experience (see Hauck, Fenwick et al. 2007, for example). The emotion has also been identified in those having an unexpected, non-elective intrapartum caesarean section.

An investigation into Saudi Arabian women's experiences of the procedure by Al-Nuaim reported having a caesarean section to be "profoundly disappointing" (2004, p.708). Reichert, Baron and Fawcett (1993) reported three qualitative studies conducted between 1973 and 1990 with different groups of women who'd had either a scheduled or an unscheduled caesarean section. Reichert and team found that although those having an unscheduled caesarean section were found to be less able to adapt to the intervention than were those who were expecting it, one of the dominant responses of all women was "disappointment about having to have a cesarean delivery" (1993, p.163). Several participants in Churchill, Savage and Francome's survey of British women's perceptions of caesarean section, too, were quoted as "disappointed", "let down" and "upset that I was not able to see a natural birth through" (2006, p.141). This is a serious cause for problem given Harwood, McLean and Durkin's (2007) finding that depression symptomatology was greater in women who experienced disappointment around the time of becoming a new mother than in those who didn't.

In the context of childbearing, a clear link has also been identified between a previous disappointing caesarean section and future birth-related decision-making. In their discussion around birth mode in a subsequent pregnancy after previous caesarean section, Fenwick, Gamble and Hauck (2006) found "the medical discourse that promoted C(aesarean) S(ection) as the safest option" to be a major influence on Australian women's decisions. These researchers also found that "as a result, (women) reconstructed C(aesarean) S(ection) as an acceptable alternative that was safer for them and their babies, allowed them to be better prepared, and was convenient" (p.121). Women's preference for a repeat planned caesarean section in Fenwick *et al's* (2006) research was a result of women reframing birth as uncertain, unachievable and potential dangerous. There is little doubt however that women's sense of disappointment with the previous birth was also reported to be a factor in the

decision (p. 126).

Decision-aversion concerning future childbearing may also manifest itself as voluntary secondary infertility. Although disappointment with the experience is not explicitly reported to be the reason, the fact that a number of research teams have found those who have had a caesarean section to demonstrate a far greater tendency to avoid conceiving again than do other women strongly indicates that it may be the case (Jolly, Walker et al. 1999; Mollison, Porter et al. 2005; Bhattacharya, Porter et al. 2006; Tollånes, Melve et al. 2007).

In the current study, fear was also a feature of the women's reactions to needing a scheduled caesarean section. While some were able to pinpoint exactly what they were frightened of, for example not being in control, not bonding with the baby, disaster/disability, or death, many were not. The work concerning antenatal fear in the context of elective caesarean section is thus far very limited. The majority of the research on fear of childbirth during pregnancy is concerned with vaginal birth. Cross-culturally, researchers have found that women fear labour pain, problems and procedures, the attitude of health care personnel, and the consequences for their sexual capability, among other things (see Serçekuş and Okumuş 2009 for example). Where childbearing women's fear is reported in relation to caesarean section, it is largely from an *intrapartum* and/or *postnatal* perspective and about the need for non-elective caesarean section (as in the work by Ryding 1991; Johnson and Slade 2002; Tsui, Pang et al. 2006; Waldenström, Hildingsson et al. 2006; Fenwick, Staff et al. 2008; Kringeland, Daltveit et al. 2009; Laursen, Johansen et al. 2009; Nieminen, Stephansson et al. 2009). Two papers however were identified that reported the phenomenon in women having an elective procedure.

The first of these features the early work of Affonso and Stichler (1978). These investigators explored American women's reactions to needing and having an elective caesarean section and found fear to be a feature of the experience. Using a questionnaire, the investigators identified that, for almost 90% of the 105 women who participated, fear was the predominant emotion. Like the women in the current study, the participants in Affonso and Stichler's research feared both the procedure itself and potential negative outcomes, including dying. Differences were however noted in relation to the fear of pain and fear that having a caesarean section would

change their relationship with their partner and children. The second much later paper involved a qualitative study undertaken by Ying, Levy, Shan, Hung and Wah (2001) with 18 Hong Kong Chinese women who had elective caesarean sections. These researchers also identified high levels of apprehension, insecurity and fear as features of the experience. Like the women in the study reported in this thesis, those in Ying and associates' investigation "expressed a need for more information" (p. 118) and attributed their worry and insecurity to lack of knowledge about "what would happen and how they would feel afterwards" (p. 117). The implication in the exemplary quotes featured by Ying and colleagues reflects a synergy with the current study in that women stated that the procedure was not explained to them by staff to a degree that was helpful and calming to them.

Other work on childbirth fear focuses on its role in suboptimal maternal psychological and emotional well-being. This too, however, is related to the postnatal rather than the antenatal period. A number of papers implicate childbirth fear in, for instance, birth-related post-traumatic stress, in postnatal depression and in childbirth complications such as dystocia (Areskog, Uddenberg et al. 1984; Hofberg and Ward 2003; Laursen, Johansen et al. 2009; Söderquist, Wijma et al. 2009). To date though, it would seem that a forthcoming scheduled caesarean section has not been consistently reported as the cause of women's childbirth fear, as was found in the current study. Nor have the specific pre-caesarean fears that these women disclosed, including loss of control, failure to bond with the baby, physiological catastrophe and death been previously identified. From this perspective, the findings of the study reported in this thesis make a significant and unique contribution to the body of knowledge on this subject. This is also the case where death- and disaster-related childbirth fear is concerned.

References to childbirth fears about death and disaster are again featured from the intrapartum rather than the antenatal perspective, with research in this area having been predominantly focused on the development of postnatal post-traumatic stress syndrome symptoms (Creedy, Shochet et al. 2000 provides an example). An exception to this is the more recent work of Swedish researchers Söderquist, Wijma and Wijma (2004), who identified the presence of antenatal *pre*-traumatic stress symptoms in women who perceive childbirth will be threatening or frightening. All formal criteria for a diagnosis of posttraumatic stress disorder (PTSD) were met by

2.3% of Söderquist and team's sample. This means women affirmed a sense of "threatened death or serious injury, or other threat to one's physical integrity" (American Psychiatric Association 1994). From this evidence it is possible to deduce that the two women in the current study who feared their caesarean section would end in disaster or death were likely to have been experiencing an anticipatory form of PTSD similar to women in Söderquist and associates' (2004) study. More recently, a phenomenological study by Swedish investigators Nilsson and Lundgren describes how women experience childbirth fear. Their findings resemble those articulated in this thesis, in that the women were concerned with feeling "danger that threatens" (2009, p.e1). The general fear of the operative procedure that most of the women in the current study described has, however, yet to be reported in the maternity literature or in the wider body of healthcare evidence.

Neither could these women's experiences be contextualised in research concerning the experience of anticipatory fear in other surgical patient populations, for none seemingly exists. A few studies concerned with pre-operative anxiety in 'day case' or 'ambulatory surgery' are reported, but are largely quantitative in nature, concerned with incidence, and feature either the experience of children or their parents, or both. Where adult patients' experience of pre-operative anxiety is described, it is in the context of anticipating having a general anaesthetic (which the women in the current study were not), and/or describes the phenomenon in the immediate pre-operative minutes or hours, not the prior days and weeks in which the current study women's fear manifested. Mitchell (2003), in his review of 34 published studies on the subject of anxiety in surgical patients, does report that slightly higher pre-operative anxiety is associated with being female and being a 'novice' patient, which may be relevant. Ultimately, though, it would seem that the incidence and nature of women's antenatal fear of caesarean section is as yet unaccounted for, and very little evidence exists against which to consider this aspect of the current study women's experience.

Loss of others' regard and esteem

In tandem with a loss of joy, participants in this research expressed that a scheduled caesarean section robbed them of their status as a strong, capable, birthing woman. This aspect of women's experience included social denigration as inferior to those birthing naturally. A degree of vilification by some hospital staff members was also apparent in the data. Despite an extensive search of the childbirth literature, no

research could be located that described similar experiences. Research in the social sciences domain has, however, reported on the stigmatisation experienced by the unemployed. This work may go some way towards explaining this aspect of women's experience.

Using a survey design, Swedish sociologists Furåker and Blomsterberg (2003) explored attitudes towards those who have lost their paid job of work, and described how they can expect to be "more or less looked down on by their environment". These findings supported earlier work (such as Goffman 1963; Hayes and Nutman 1981; Furnham 1982; Gallie 1994; Rantakeisu, Starrin et al. 1997; Paugam and Russell 2000) which indicated that the stigmatisation associated with unemployment stemmed from a perception that joblessness was due to personal shortcomings or a blemished character. In other words, it is a person's own fault they are not in work. Respondents to Furåker and Blomsterberg's survey tended to consider that unemployment was "mainly due to individuals themselves", and that they "could find a job if they wanted to" (p. 200). This work resonates closely with the experience of the women in the current study, all of whom expressed being judged as 'at fault' for needing a scheduled caesarean section.

The extant literature does not really offer any insight into why the women in the current study might have felt judged. Although vaginal birth is reportedly considered by childbearing women as superior to caesarean section, nowhere has it been reported that this view is associated with a diminished view of those who have a caesarean section. In their investigation into opinions about different birth modes, for instance, Osis and colleagues' (2001) found that Brazilian women valued vaginal birth as 'better' than caesarean section (p. S63) while Kolip (2008), in a study of 1339 German women's attitudes to caesarean section, reported that two-thirds of their sample expressed the view that women should always try to deliver vaginally. In neither of these studies, though, was any opinion reported about women who did not have a natural birth.

There is some literature, however, that supports the notion that women may in fact themselves really question whether having a caesarean section does equate to giving birth. For example Churchill (1997), in her extensive survey of caesarean section practices and experiences in the UK, cites a case of a woman self-identifying as "a

freak – not a “real” woman” (p. 90) after having birthed in this way. Nine years later in a follow up survey, Churchill and associates (2006) provided evidence that some women question whether having a caesarean section means they have given birth. While this finding resonates closely with the experience of the women in the current study, it doesn’t explain their perception of others having this view towards them.

It is also possible that women’s sense of being negatively judged by others was related to the ongoing social and professional discourse about the merits or otherwise of scheduled caesarean section. The debate is most often posed as a moral and ethical dilemma embedded in a ‘pros vs. cons’ dispute, and is focused on the right of women to choose to schedule a caesarean section in the absence of medical indications. This is despite the fact that caesarean section is a complex and major surgical procedure (Williams 2008; Obstetrics and Gynecology Risk Research Group, Kuppermann et al. 2009). On one side is the view that any woman should be able to choose a scheduled caesarean section, even in the absence of an obstetric indication, if they so wish (as argued, for example, by Steer 1998; Minkhoff and Chervenak 2003; Fisk and Paterson Brown 2004; Schwartz 2004). The counter-argument vehemently opposes this stance based on the evidence that caesarean section poses a greater health risk to both mother and child (see Churchill, Savage et al. 2006; Kalish, McCullough et al. 2008 for instance). The literature also reflects a conviction that if women were truly aware of the risks associated with caesarean section, they would not request it (Bergeron 2007).

In the media, women who choose medically unnecessary scheduled caesarean section are presumed to do so in an effort to avoid the indignity of natural birth. This had led to women being dismissed in newspaper articles as either “too posh to push” (Shorten 2004; Song 2004) or “too smart to suffer” (McGinty 2005). Despite the fact that no woman in the current study chose caesarean section, it was their perception that commonly, others assumed they had. The women found that they were either denigrated or celebrated for what others perceived as their ‘choice’ when in fact they had little say in the outcome and did not want to have the procedure.

Loss of the opportunity to complete certain rites of childbearing

For the women in the current study, becoming in need of a caesarean section also meant they were excluded from participating in certain childbirth rituals such as

attending antenatal classes, visiting the area of the hospital where their baby would be born, and completing a birth plan. The sense of loss generated by this exclusion suggests that these activities represent essential components in the contemporary construct of what having a baby entails and 'is'.

Some research exists reporting specific childbearing customs and practices of particular cultural groups (as in the paper on the perinatal beliefs and practices of immigrant Punjabi women living in Canada by Grewal, Bhagat et al. 2008, for example) and rituals followed either during efforts to conceive or after a baby's death (see for instance Mason 1992; Kemmann, Cheron et al. 1998). The findings of the study reported in this thesis, however, offer insights not evident in any currently published literature about the importance to women of completing particular pregnancy rites. Midwife theorist Rubin's early work around maternal identity and maternal tasks of pregnancy, however, does shed some light on the sense of loss associated with being unable to perform those rites.

In this work, Rubin (1976) argues that the motivational behaviour of pregnant women is based on four interdependent goals. These include,

- (1) seeking safe passage for herself and her child through pregnancy, labor and delivery;
- (2) ensuring the acceptance of the child she bears by significant persons in her family;
- (3) binding-in to her unknown child;
- and (4) learning to give of herself

The first 'task' of seeking safe passage involves pregnant women engaging in various protective behaviours. While women are principally concerned with their own personal safety in the first trimester, their focus shifts onto the baby once the reality of the pregnancy is personally and outwardly evident. Their 'work' then becomes directed towards making a 'good' baby and guarding against damage to him or her. This essentially entails the seeking of many forms of information and care that will minimise threat or harm. The information-seeking behaviour examples Rubin gives include reading books and magazines, watching films and television programmes, talking with other women deemed as having expertise in childbearing, and consulting with maternity care professionals. It is possible that women consider antenatal classes to provide a forum from which they are likely to obtain many of these forms of information, and that by not attending they are missing out on learning something

that may have an impact on their baby's wellbeing.

Rubin also observed that it is women's natural tendency to perceive the hospital birthing environment as threatening, intrusive and potentially damaging (1976). When this is considered in the context of women's need to facilitate 'safe passage' for their baby, one can understand the sense of loss the women in the current study felt at being unable to visit and become familiar with the birth space in advance of their scheduled caesarean section. Additionally, when women's need to retain control over their childbearing experience is considered in this context, it becomes clear that not being able to formally document their wishes for their baby's birth in the form of a birth plan represents a loss of something valued and important.

Loss of connection to the baby

The final significant loss identified in the current study was that of the instant deep emotional connection women felt to their newborn immediately following birth. Women were only in contact with their baby for a very short time in the operating room and then did not see them again for at least one hour. The women in this study clearly articulated that they felt differently towards their newborn by the time they returned to the ward, and that 'rooming in' thereafter did not result in the connection being recaptured.

Although there is much anecdotal information available describing an absence of newborn connectedness in caesarean section mothers (see the article by Udy 2008, for example), the current study provides unique insights into the loss of connection after it has been felt. Studies of mother-newborn bonding behaviour in humans and in other mammals strongly suggest a biological basis for the initial intense connection women felt to their baby. The reasons why this bond was not sustained following the very early separation of the mother-baby dyad can also be found in the human and animal literature. In particular, research concerned with the effect of fear on oxytocin production, or rather of the production of noradrenaline in the presence of fear, offers a likely explanation for women's overwhelming yearning for their baby in the first instance.

According to Tanaka and associates (2000), fear and anxiety evoked by emotionally stressful events are known to cause a marked increase in the release of noradrenaline. Regardless of the mode of delivery, parturition is one such stressful event during

which women's plasma noradrenaline levels have been found to peak (Jouppila, Puolakka et al. 1984). Studies of female sheep and cattle demonstrate that raised circulating noradrenaline levels stimulate the release of oxytocin (Heap, Fleet et al. 1989; Kotwica, Skarzynski et al. 1991). Oxytocin is now well established as the hormone of love that endears or 'addicts' a woman to a helpless newborn baby (Pedersen and Prange Jr 1979; Uvnäs-Moberg 1997). When applied to the findings of the current study, it is possible to see how the instant rush of love felt by the women towards their baby in the first instance may have been engendered by their intra-operative (intrapartum) fear and stress.

Once initiated, the maintenance of the immediate primal mother-baby connection is dependent on sustained contact between the two. Findings from animal studies that have since been extrapolated to humans (Rosenblatt 1994) demonstrated that for both maternal acceptance of the infant and the firm establishment of maternal behaviour to occur, continual contact between mother and infant for several hours after birth is necessary (Rosenblatt 1975; Poindron, Lévy et al. 1988; Siegel and Rosenblatt 1990). Early human research by Stern (1977), Oliver and Oliver (1978) and others led to the advocacy of uninterrupted face-to-face contact between mother and baby following delivery to 'cement' the attachment between them. In later work, German researchers Hentschel, Ruff, Juette, von Gontard and Gortner (2007) hypothesised that it is innate in human newborns to actively try and engage their mother almost immediately following birth. These researchers recorded the facial movements of babies in the immediate postnatal period. Following close observation of 133 neonates, 95% of the well term babies studied began earnest eye opening and blinking within three minutes of being born. In addition, 97% of the babies began focused tongue-thrusting in the same timeframe. Hentschel and colleagues concluded that these two behaviours are the means by which newborns sustain and strengthen their mother's attachment to them. Also now well established is the fact that undisturbed skin-to-skin contact between mother and baby immediately after birth is significantly associated with the development of a positive attachment between the two (Moore, Anderson et al. 2007).

The amount of contact time necessary to foster a strong 'bond' has also been reported in both human and animal research. In a recent study investigating the effect of separating mothers from their newborns post-birth, Bystrova and team (2009)

identified the optimal period of uninterrupted skin-to-skin contact to be between 25 and 120 minutes. Women who were kept together with their baby for this length of time were observed to have far greater sensitivity to their infant at one year than were mothers who were separated from their baby for up to two hours after birth. Research into the maternal role development of rodents and sheep has reported similar findings. Such studies have found and confirmed that for both maternal acceptance of the infant and the firm establishment of maternal behaviour, continual contact between mother and infant in the hours after birth is necessary (Rosenblatt 1975; Poindron, Lévy et al. 1988; Siegel and Rosenblatt 1990).

In addition, lack of genital stimulation during caesarean section may also have a part to play in the non-formation of a strong maternal-infant connection. Studies of ewes have found that, as well as being triggered by high circulating levels of noradrenaline, oxytocin release is triggered by the passing of the fetus through the birth canal and that this is necessary for the formation of a lasting bond. Poindron and team (1988) discovered this to be the case in a study that investigated the effects of anaesthetising ewes' genitalia; indifference to their offspring was the result. To confirm the results, these researchers also tested whether artificial genital stimulation of potential adoptive ewe mothers would increase the likelihood that they would accept 'alien' orphan offspring, and found that it guaranteed they would. At this stage it is not possible to make any direct connections from animal studies about genital stimulation to the human population; however it is worth noting that existing, albeit limited, work exists in this area at this time.

The contribution of institutional paternalism to birthing redundancy

While framing the disintegration of childbirth expectations as personal losses helps explain the women's disappointment and distress it is clear that women's inability to fulfil their desired role was also a result of fundamental differences in beliefs about who 'owns' childbirth. The women and the maternity service each held the view that responsibility for the safe passage of a baby from its mother's body to extra-uterine life belonged to them. It is beyond the scope of this thesis to provide a full discussion of childbirth paradigms; however a review of the key tenets of the paternalist and the feminist worldview of childbearing is useful in explaining how a conflict of philosophies contributed to women's sense of redundancy.

According to Purdy (1990), it is the view of the medical profession that pregnant women are no more than unreliable fetal containers. Sociologist Wetterberg (2004) and gender theorist Hausman (2005) concur with this assertion, and suggest that this view is largely due to medicine's predominant focus on the fetus. Using a Foucauldian framework to deconstruct the medical view of the pregnant woman, Wetterberg (2004) found the fetus to be considered a 'separate person' and the pregnant woman merely as its caretaker. Furthermore, Wetterberg suggests that medicine has constructed the expectant mother to represent the main risk factor in fetal outcomes. Hausman (2005) similarly framed the medical perspective on pregnancy and birth as paternalistic and misogynistic, in that the fetus is considered autonomous and of central problem, and technology as more dependable than the female body for facilitating safe birth. There seems little doubt that this worldview is reflected in the findings of the current study, wherein the maternity care staff's construct of a scheduled caesarean section as an operation rather than a birth confirms that collectively they saw themselves as the owners of the caesarean section procedure, and women as having nothing to contribute except as a housing for the fetus.

Within a two-sided context of societal acceptance of surgery as the domain of the health professions and a power imbalance in favour of the maternity service, the women in this study had little choice but to comply with this approach to birth. The hospital framed caesarean section as an operation, and in the women's minds, operations 'belonged' to and were the domain of health care professionals. Additionally, women perceived that for the procedure to go well, they had to prioritise the professionals' needs above their own during their caesarean section. The way the women in this study tried to 'disappear' and 'behave' during their caesarean section, and the distress they felt at not being able to control their emotional responses whilst on the operating table, clearly suggest this was the case. Childbearing from this perspective, though, completely opposes the feminist view of the process as a deeply significant biopsychocultural female activity, one that is essential for women to be involved in for their optimal transition to motherhood (Reiger and Dempsey 2006). The paternalist approach also resists the extensive body of work that considers a mother and her baby to be a dynamic, synchronous and interdependent dyad, the maintenance of which is well known essential for the

development of a secure mother-baby attachment (Reyna and Pickler 2009). This helps explain women's sense of being left wanting after their scheduled caesarean section.

By extension, this work also provides some insight into why the women in the current study might have had difficulty settling on a way to frame their experience. Although on one level the women recognised that doctors must perform and take ownership of their baby's birth, this acknowledgement was evidently at odds with women's core feminine emotional and intuitive knowledge that they should be centrally involved in their baby's birth. The hospital staff's lack of appreciation that these women still considered they were giving birth, and its ignorance of women's primal need to be involved in their childbearing experience, were later found to be of seminal importance in women feeling bewildered, empty and as if 'treading water' in the early postnatal period. The staff's near-total focus on the caesarean procedure, and their construction of it as a routine non-event contributed significantly to women's sense of loss. In the next section, women responses to their convergent psychosocial losses are explored.

Reacting to psychosocial loss

Having expected and wanted a natural birth, the women in the current study all reported being deeply disappointed by needing and having a scheduled caesarean section. Despite their efforts to shift their focus and feel more positive, women's feelings of loss and distress persisted and were still evident some 10 to 14 weeks after birth. In this section of the chapter, the women's experience will be considered in the light of the maternity literature and other scientific and theoretical work reporting on the human reaction to loss. Specifically, the women's sense of redundancy will be discussed in the context of the substantial body of work on grief and traumatic stress.

Grief

Grief has been classed in a variety of ways since Freud first reported the condition as a 'state of melancholy' in 1917 (Freud 1917). Lindemann (1944) identified it as a 'syndrome', and Engel (1961; Engel 1964) classed it as a 'disease' based upon the condition having a clear cause of onset (loss), a predictable course and physical, affective, cognitive, psychological and behavioural symptoms. In later work, both

Graves (1978) and Tully (2003) labelled grief as a complex state of affective, cognitive and physiological ‘turmoil’. Regardless of how grief is classified, though, the early-stage characteristics of the condition have consistently been described to include shock, incomprehension, numbness, an empty feeling in the stomach, disbelief, denial, crying, raging and confusion. Sadness, depression, anxiety, anger, pining, social and personal withdrawal, as well as other somatic symptoms, have been found to follow later in the process (Burton 1832; Reed 1998; Jeffreys 2002; Fadem 2008; Clark 2009). The women in the current study experienced many of these responses, which strongly suggest that the loss of their anticipated natural birth invoked an acute grief response.

While literature reporting and describing antenatal grief does exist, this is largely concerned with the death of the baby during pregnancy or birth (Cacciatore and Bushfield 2007; Ekelin, Crang-Svalenius et al. 2008; McCreight 2008; Gerber-Epstein, Leichtentritt et al. 2009); there has seemingly been no previous work investigating a grief response specifically in relation to becoming in need of a scheduled caesarean section. There are, however, two published studies that identify postnatal grief in women who have had an unexpected caesarean section. The earliest of these studies simply found evidence of a sense of loss and grief across a group of American childbearing women (Birdsong 1981). The later publication by Fisher, Astbury and Smith (1997) concluded it to be highly likely that non-elective caesarean section had “very adverse effects” on English women’s postnatal mood and self-esteem (p. 733). According to these authors, such effects rendered the women “vulnerable to a grief reaction” (p. 728).

If the need for a caesarean section is framed as an involuntary loss, the literature does yield more information against which to consider these women’s experiences. The findings of Carter’s (1989) qualitative study of the response of 30 American adults to the sudden death of a loved one, for example, strongly echo the experience of feeling robbed reported by the women in this thesis. Like the women in the current study, Carter’s participants described being unable to believe the reality of the situation. The feeling of their loss “as a kind of emptiness... a hole, void or vacuum” (Carter 1989) is also synonymous with the Australian women’s sense of feeling “gutted” and “deflated”. In addition, the experience of loss was reported in both groups to induce feelings of being overpowered by the situation, of loss of control, and of

helplessness.

Similarities exist, too, between the findings reported in this thesis and literature that describes the grief associated with involuntary job loss. In a study conducted in the early 1990s, Archer and Rhodes (1993) investigated the applicability of the grief process to redundancy from paid work. Data were collected using structured interviews with 70 English men who had experienced involuntary and unexpected job loss. The researchers found that, like the women in the current study, participants felt shocked, in denial and a “loss of self” (p. 402) when they were made redundant. As well, despite no longer being in their post, Archer and Rhodes’ (1993) participants tended to retain their previous “occupational identity” (p. 398), just as the women in the current study retained their identity as a birthing woman. More recently, Australian researcher Vickers (2009) investigated the personal experience and meaning of redundancy for 10 adults. Taking a phenomenological approach, Vickers (2009) conducted in-depth interviews with nine men and one woman. Like Archer and Rhodes’ (1993), anger and denial were also a feature of Vickers’ (2009) participants’ experiences. In addition, Vickers also identified “confusion” (p. 408), a “sense of humiliation, of being demeaned and treated inappropriately and insensitively” and feelings of “indignity” in respondents’ accounts of their experience (p. 410). These descriptions are closely reminiscent of the data reported in this thesis.

Traumatic stress

As well as grief, feelings of helplessness, isolation, existential separateness and fear were engendered in the women as a result of becoming redundant. These are feelings that are known to be synonymous with traumatic stress (Figley 1985; Harvey 1996). There is a growing body of literature that confirms traumatic stress as the likely response of women whose worldview of childbirth has been shattered. Thus far, however, this work has focused on the development of the condition after a confronting birth experience; the invocation of a traumatic stress response in the antenatal period following a change of plan and the disintegration of expectations during pregnancy does not yet seem to have been investigated.

The earliest reported recognition of traumatic stress in relation to childbirth was provided by Ballard, Stanley and Brockington (1995). These authors’ case review of four women with symptoms of the condition led them to conclude that a “difficult

childbirth” was the cause of its development (p. 525). Later work by Reynolds’ (1997) provides more information describing the nature of the symptoms experienced by birth-traumatised women. Specifically, peritraumatic depersonalisation and disassociation were identified as key profile features of women’s experiences. Around the same time as Reynolds’ (1997) work was published, Ryding and colleagues (1998) documented the trajectory of childbirth-related posttraumatic stress in women who had experienced emergency caesarean section. These Swedish authors found that, like the women in the current investigation, participants’ outlook changed around the time of the decision for intervention from one of safety and confidence to one of fear (p. 249). Also of note is the discovery in Beck’s later (2004) study of birth trauma that, similar to the participants in the current study, what was traumatic to women was either not acknowledged by clinicians or was considered to be of no matter or consequence.

The women in this study, like the Canadian participants in Reynolds’ (1997) research, also reported entering into a state of mind-body dissociation during their caesarean section. Unlike their Canadian counterparts, however, the Australian women’s dissociation was a pre-conceived, intentional, fully conscious and rehearsed act of coping. A similar example of psychological preparedness work was found in a sample of children and adolescents anticipating a natural disaster. American team Kiser and colleagues (1993) found that participants had visualised, enacted and prepared a response to the incident in their minds (Kiser, Heston et al. 1993). Anticipatory dissociation as a planned approach to dealing with a pending traumatic incident, though, has not been otherwise reported in the literature and it would seem that, in relation to childbearing, this is a unique finding of the current study.

Health implications of loss, grief and traumatic stress

For a woman to perceive her birth experience as positive, her priority expectations of the event must have been met (Hauck, Fenwick et al. 2007). Consequently, when the birth experience does not live up to expectations within a context devoid of respect, women are unlikely to evaluate it particularly positively (Heaman, Beaton et al. 1992; Green 1993; Goodman, Mackey et al. 2004). Among the repercussions for women of feeling negatively about the birth event is a diminished level of confidence and trust in childbirth. In turn, low or altered maternal mood can have far-reaching

consequences for their child/ren's emotional, behavioural and cognitive development (Field 1992; Murray 1992; Sinclair and Murray 1998).

According to Ayers and Pickering (2005), there is a cyclical aspect to childbirth disappointment in that women who experience and recall their baby's birth negatively will expect it to be that way next time, and having an expectation that birth will be a negative event predisposes it to be so. Wariness of childbirth, particularly when it stems from previous experience, has been shown to incline women towards future fear of childbirth (Melender 2002; Saisto and Halmesmäki 2003). Additionally, Hauck and colleagues (2007) found that, in an attempt to avoid a recurrence of their previous childbirth disappointment, women whose experience had been unaffirming were found to adjust their expectations. Predominately women shifted from a belief in natural birth and the importance of the process to a preference for medical management and the expectation that birth was 'only' about having a healthy baby. These researchers argued that having no expectations for oneself meant that there was little opportunity for cognitive dissonance to occur in a subsequent pregnancy.

Antenatal fear of childbirth has also been independently associated with childbirth intervention, including epidural use and caesarean section (Fenwick, Gamble et al. 2009). Given the majority of women's preference for a natural birth (Fenwick, Hauck et al. 2005), increased intervention is likely to compound women's disappointment with childbirth. The evidence as a whole suggests that while women feel a sense of loss and disappointment about their birth experience, there is little hope that the rising caesarean section rate will abate.

The women reported in this thesis were followed to 10-14 weeks after the birth event, at which point they still demonstrated signs and symptoms indicative of grief and traumatic stress in relation to their loss/es and associated disappointment. Research suggests, however, that grief and traumatic stress both persist well beyond 10-14 weeks and, like disappointment, potentially both have serious implications for women's and children's well-being. The symptoms of grief, specifically depressive symptoms, and traumatic stress can exist concurrently, and are similar in many ways (Ballard, Stanley et al. 1995; Friedman 2000).

The health consequences of grieving are well reported in the literature, however this

work is predominantly concerned with death-related rather than perceived loss. There is seemingly no existing work on how grief resulting from a psychosocial loss such as a disappointing birth experience affects women's general health. It is argued by many, though, that the grief response is similar regardless of the type of loss incurred (Archer and Rhodes 1993). It is likely, therefore, that the health on-costs of grief may also be seen in all populations. Although not all who grieve also suffer serious allied health problems, a number of people do (Stroebe, Schut et al. 2007). Vulnerability to decrements in physical health and the development of psychological symptoms and illnesses seemingly correlate to the intensity of one's grief. At four months post-loss, for example, widowed women whose grief was of high intensity were observed to be at increased risk of high blood pressure, heart attack and functional impairment compared to women with low intensity grief (Prigerson, Silverman et al. 2001). When compared to matched controls, though, those experiencing grief to any extent are more susceptible to increased physical co-morbidities in comparison to those who have not experienced a loss regardless of the depth of grief. The incidence of headaches, dizziness, indigestion, chest pain and general illness, and the correlational use of medical services and drugs, for instance, are increased in grieving subjects (Parkes 1996; Stroebe, Hansson et al. 2008).

Reportedly, psychological and psychiatric complications of grief most commonly develop in the immediate post-loss period and abate over time (Parkes 1996; Byrne and Raphael 1997; Archer 1999; Stroebe, Hansson et al. 2001). These include affective and cognitive reactions such as despair, dejection, distress, yearning, self-accusation and self-reproach, preoccupation with the lost object, intrusive ruminations and difficulty concentrating, helplessness and a sense of unreality. Behavioural symptoms such as agitation, restlessness, 'searching', loneliness and insomnia have also been noted in the presence of grief (Lund, Caserta et al. 1993; van Baarsen, van Duijn et al. 2001-2; Hansson and Stroebe 2003; Hardison, Neimeyer et al. 2005; Stroebe, Hansson et al. 2008), as have insomnia, social dysfunction and symptoms of depression and anxiety, at six months (Byrne and Raphael 1997; Chen, Bierhals et al. 1999). In some cases, symptoms of depression and anxiety can become established (Raphael, Minkov et al. 2001) and while 25%-45% of grieving people report mild depressive symptoms, 10-20% go on to develop clinical depression (Hansson and Stroebe 2003).

Generally though, loss is recognised as a normal, if stressful, life event. Adequate recovery from the grief that usually results from loss is expected to occur spontaneously over time (McCrae and Costa 1993; Boerner, Wortman et al. 2005; Prigerson, Horowitz et al. 2009). The length of time before resolution occurs, however, is known to be “months or even years” (Stroebe, Schut et al. 2007, p.1960). While for most the symptoms are likely to become less intense over time, Prigerson and Maciejewski (2005) consider grief to have become complicated if the sufferer fulfils a number of criteria that demonstrate unchanged grief intensity over at least six months. These include a chronic and disruptive longing or pining for the lost object, four other symptoms at a degree intense enough to be disruptive (from a range including trouble accepting the loss, inability to trust others, excessive bitterness or anger related to the loss, uneasy about moving on, numb or detached, feeling life is empty or meaningless without the lost object, bleak future, agitated), and social, occupational or other dysfunction. Later work by Prigerson and colleagues (2009) confirmed that the presence of these characteristics at six months post-loss were predictors of enduring distress and dysfunction.

Perhaps of greatest problem is the known connection between grieving and heightened risk of death. Excess risk of mortality has most commonly been found to occur in the early grief period (Mendes de Leon, Kasl et al. 1993; Martikainen and Valkonen 1996; Martikainen and Valkonen 1996; Lichtenstein, Gatz et al. 1998; Manor and Eisenbach 2003). Some studies have, however, noted the risk to persist for at least six months and up to at least 20 years after the loss (Schaefer, Quesenberry et al. 1995; Martikainen and Valkonen 1996; Li, Precht et al. 2003). The causes of increased mortality risk are varied and are largely relative to age and lifestyle. Where loss-survivors subsequently die from unnatural causes, though, it is most commonly by suicide. There is no published research reporting a causal link between the grief associated with a deeply disappointing birth experience and subsequent maternal death, however the number of women who die by their own hand in the first year postpartum is known or suspected to contribute significantly to the International maternal mortality statistics in recent years (Oates 2003; Austin, Kildea et al. 2007; Chen and Lau 2008)

Studies investigating the course of traumatic stress *per se* suggest that where the condition is mild, symptoms are likely to diminish over the year following the event,

however the more severe the trauma, the longer it will take to abate (Andrykowski, Cordova et al. 2000). In research undertaken some years on, Söderquist, Wijma and Wijma (2006) also found this to be the case in the childbearing population; Söderquist and colleagues (2006) found that 19 per cent of women who reported experiencing traumatic stress at one month postpartum in this study also reported it at 11 months. Later work by Sorenson and Tschetter (2010) further confirmed that birth-related traumatic stress persists postnatally in varying degrees of intensity. Forty-five per cent of the women in these researchers' study were found to be carrying a low residual level of birth-related traumatic stress at 6 to 7 months post-birth, while 2.7% of participants were discovered to be highly traumatised still at this time point.

According to Ayers, Eagle and Waring (2006), the effect on the future health, well-being and relationships of birthing women affected by traumatic stress is reportedly poor. In their work Ayers and team identified a myriad of issues. These included physical ill-health, altered mood and behaviour, diminished social interaction and fear of childbirth. The condition was also found to have a negative effect on women's relationship with their partner, and was associated with sexual dysfunction, disagreements and blame for events of birth. Women's relationship with and problem for their baby was also seriously affected by birth-related traumatic stress. On a positive note, Ayers and team did find that while almost their entire sample reported early feelings of rejection towards their baby, this did improve over time. In the longer term, however, the women seemed to have developed either an "avoidant" or "anxious" pattern of attachment with their child (p. 389). These findings have significant ramifications for the wellbeing of women and their children, for family functioning, and ultimately for society.

Part 2: Trying to Accommodate a New Reality

In the previous part of this chapter, the discussion focused on scholarship that explained how women's need for an unwanted caesarean section represented a change that invoked feelings of loss, disappointment, grief and a form of traumatic stress. The possible implications for women's health and well-being were also identified. Now, the way the women negotiated their way through their feelings and emotions will be considered in the light of Parkes' (1971) 'psychosocial transition'

theory. The developmental consequences for babies whose mothers have been unable to fully transition change or loss at the time of childbearing are also put forward in the context of theoretical work on infant attachment and ‘continuing bonds’.

The emotional regrouping work that women undertook in the face of an enforced, unwelcome change to their childbearing course demonstrated two fundamental aspects. Firstly, women concerned themselves with accepting and accommodating the change foisted upon them. This involved attempting to verify the necessity of the procedure, determining some ‘positives’ about it, and looking for a way to stay present and involved in their baby’s birth. Secondly, women sought to make meaning of their new reality. This entailed women trying to work out what needing and having a scheduled caesarean meant to and for them, as well as what it meant for their relationship with their baby. As was the case with scheduled caesarean section being theorised as a redundancy, the strategy used by women to deal with having an unwanted and unexpected scheduled caesarean section has not previously been reported in the literature. The concept of regrouping has, though, been identified in other contexts.

Political writer Hill (2004) for example, in his discussion paper on foreign policy development following a devastating terrorist attack, described regrouping as a reviewing exercise aimed at taking government “on to the next stage” (p. 143). Further confirmation of the term as appropriate is also found in the Arts and the Social Sciences. Spatial design theorists Suwa and colleagues postulated that when artists ‘regroup’ elements of their sketches, they seek “new wholes, with different meanings” (Suwa, Tversky et al. 2001). Social work writer Sullivan (1998), when exploring the experience of living with a serious mental illness, also used the term ‘regrouping’ to describe how sufferers try to “make sense of their lives and to survive on a day-to-day basis” (p. 25). All of these interpretations of the term ‘regrouping’ echo the implicit aims of the women in the current study - to move forward, to discover who they were now, and to make sense of a bewildering situation. In the next section, women’s regrouping actions are considered in the context of psychosocial transition theory.

Change, loss and psychosocial transitioning

The regrouping work women engaged in was undertaken in an effort to keep abreast

of a disruptive change that was occurring to their childbearing course and in an effort to deal with the object losses that ensued. As discussed earlier, at the time the change occurred, women experienced an acute involuntary grief reaction. Once this initial response had abated somewhat, the women then consciously engaged in cognitive and behavioural remedial work. This patterned response to change is well recognised in the literature; the process is known to be necessary for making sense of and integrating the losses inherent in change, and for the construction and movement into a new reality (Martin and Doka 2000). When the process is followed after the loss through death of a valued person, it is commonly referred to as mourning. Other kinds of change and loss, however, such as those experienced by the women in the current study, are more likely to be accommodated by a process of transition (Williams 1999). Parkes (Parkes 1993) defines psychosocial transitioning as the adaptive process undertaken in order to become more familiar with, at ease in and in command of one's journey through a new landscape. As such, psychosocial transitioning theory provides a useful context in which to explain the regrouping response mounted by women in response to the change to their childbearing course.

According to Parkes (1993), when individuals are faced with loss they are forced to review and adapt assumptions about the world that they have held for some time. Loss essentially invalidates the internal world through or against which incoming sensory data has, up to that point, been matched; it also annuls the means by which self-orientation, recognition of what is happening, and how one has planned to conduct oneself have occurred (Parkes 2000). When one's assumptions are thus shattered, familiarity is gone and this naturally causes insecurity, as it did for the women in the current study. Commonly, resistance and grief is initially felt as a different 'landscape' presents. The bereft then becomes aware that their role and expectations will likely need to alter to be able to traverse it. Parkes (1971) asserts that a change i) must take place over a relatively short period of time so there is little opportunity for preparation, ii) be lasting in its implications rather than transient and iii) require one to undertake a revision of assumptions about the world. Having been expecting and wanting a natural birth and suddenly becoming in need of an unwanted scheduled caesarean section certainly constituted a change that met all of these three criteria.

The psychosocial transition faced by the women in this study was moderated by two

factors. The first was their attachment to giving birth naturally, and the second was having inadequate time available to adjust to their new reality. Although largely concerned with death-related loss, attachment theory (see for example Bowlby 1980; Field, Gao et al. 2005) and the ‘continuing bonds’ work of Neimeyer and team (2006) both explain how a connection to a valued other (such as, for example, a life expectation) might be problematic when the loss of that ‘other’ occurs. According to Field and colleagues, connection to attachment figures provide a safe haven in times of threat and a secure base from which to explore the world (Field, Gao et al. 2005). It could be argued that, for the participants in the current study, the ‘other’ they were attached to and lost was their self as a naturally birthing woman. This seems particularly likely given that the loss of an attachment figure is known to trigger a process of protest, despair and reorganisation as the survivor works to adapt to the loss (Bowlby 1980). Lending credulity to this argument is Freud’s (1957) assertion that detachment from the lost figure is necessary before investment in a new relationship (in these women’s case, with their new ‘self’) might occur.

Extending this line of thought, Neimeyer and associates (2006) attest that where ‘continuing bonds’ with an attachment figure remain, the grief process becomes complicated and prolonged. Their work found that being able to make positive meaning of change eased the transition of loss, while the inability to do so was associated with extended and complicated grief. Theorists in this area recognise that detachment from existing bonds or attachment figures, making meaning of loss, and the formation of new attachments is a prolonged process (see for example Bowlby 1980) for which adequate time and space is necessary. As identified earlier, the transition process may take at least a year (Parkes 1964; Maddison and Walker 1967). This work explains why the women found it impossible to fully adjust to effectively becoming someone else in the limited amount of time available between being scheduled for and having their caesarean section.

Being unable to find a way in the dark

In this section of the chapter the adaptive measures undertaken by the women at the time of the decision for caesarean section and in the remainder of the antenatal period are explored. When women were told by a medical practitioner that a scheduled caesarean section was necessary, women’s immediate reaction was one of incredulous disbelief. Consequently, their initial regrouping actions were aimed at

confirming that they really were unable to have a natural birth, to get the reality of their situation to sink in, and to discover how they should behave during the procedure. Women's ability to achieve these aims by the time of the scheduled birth however were severely limited by the short time frame and little to no useful woman centred information about the procedure. In an attempt to verify that the decision for their caesarean section was justified, the women who were unhappy about being scheduled for a caesarean section reported seeking others' opinions about it. This involved consulting other professionals, talking with friends and family, having repeat investigations such as ultrasound scans, and discussing the situation in online forums and chat rooms.

While the internet can no longer be considered new, relatively little has yet been reported in the scholarly literature on using the medium for health advice and support. The work that is available largely problems the nature and effect of online discussion among those diagnosed with breast cancer. Two examples are the studies evaluating online support by Weinberg, Schmale, Uken and Wessel (1996) and Sharf (1997). Soon after these studies were published, the online environment was recognised as an important and effective source of emotional support (Preece 1998). The perceived benefits of online support and advice have recently been reconfirmed in a study analysing content of internet message-boards by Civan and Pratt (2007). These authors found support to be "prevalent and directed towards problems in which correspondents were planning for future events or coping with emergent situations", and that correspondents shared a wealth of "expertise, including action strategies, recommended knowledge, suggested approaches, and information resources for dealing with problems" in such environments (p. 140).

To date, research concerning the use of the internet in relation to childbearing predominantly reports health initiatives rather than peer or consumer exchange. An investigation into the feasibility of an 'e-health' message communication channel by van Zupthen, Milder and Bemelmans (2009) is one such example; Adler and Zarchin's (2002) evaluation of a 'virtual focus group' conducted with pregnant women at home on bed rest provides another. One study, by Larsson (2009), was found however that reports women's use of the internet to look for information related to childbearing. In a study of 182 women, Larsson found that 84% of those who had access to the internet used it to find out more about pregnancy, childbirth

and early parenting. Most often, women simply sought information about fetal development and stages of labour, however a small number (six per cent) also reported going into chat forums (p. 17). Unfortunately Larsson (2009) does not elaborate on what his participants discussed in such forums. Nonetheless, the positive experiences of using online forums reported by the women in this thesis are confirmed by the literature that is available.

While there is no literature on second opinion-seeking specifically in relation to maternity care or the decision for caesarean section, some work does exist in the wider health field. In part, this research is concerned with the cost-saving benefits to health insurers of obtaining additional professional opinion in relation to, for instance, recommended treatment courses. An example of this work is the study by Rosenberg and colleagues (1989), which investigated patients' reactions and physician-patient communication in a mandatory surgical second opinion program. The majority of work on this subject, though, confirms that it is a natural human tendency to look for further advice about diagnosis and treatment decisions in confronting situations.

According to Bayliss (1988), health care consumers may seek another opinion either because they "perceive the proposed treatment as too radical or wrong", they wish to hear what a "more reputable" expert has to say, or they want an opportunity to discuss the situation more fully than they were able to with the original decision-maker (p. 808). Dissatisfaction with treatment discussions, level of communication and treatment was also reported in a large Dutch study of 2079 consumers (van Dalen, Groothoff et al. 2001). Similarly, in another study from the Netherlands (Mellink, van Dulmen et al. 2003), the researchers classified respondents' motives for seeking another opinion into 'internal' and 'external'. Sixty-two per cent of participants cited internal motives, including "the need for reassurance and more certainty" (p. 1492). For the remaining 38% of the cohort reasons for seeking external second opinions included being unsatisfied with the first specialist, preferring a more active role in medical decision making, and hoping for and expecting a different decision. These findings have been confirmed in both American and Japanese populations (McCarthy and Finkel 1981; Sato, Takeichi et al. 1999).

Although hearing the decision for a scheduled caesarean section was shocking for the

women in the current study, dissatisfaction with how the news was presented to or discussed with them did not emerge from the data as a feature of their experience. The need for additional opinions about their situation was spoken of only in terms of needing to be sure that the procedure really was necessary, and that in others' view, they truly were unable to give birth naturally.

Alongside trying to authenticate the decision for a scheduled caesarean section, women's efforts to accommodate their new reality also included looking to learn about the emotional experience of having one. Unfortunately, aside from advice on avoiding a caesarean section, the only information women could find was about the clinical side of the procedure. It is not possible to review all the lay information available to consumers, however it is clear from the range of consumer leaflets and brochures provided to women by maternity services both in Australia and overseas that the focus is firmly on the technicalities of the operation (see Oxford Radcliffe Hospitals NHS Trust 2007 for example; Royal Hospital for Women 2010). In the absence of any guidance advising them otherwise, women constructed a birth plan for their caesarean section that included a role for themselves as an inert, silent, trouble-free 'fixed target'. This was a consequence of their presumption that they would need to remain perfectly still so as not to irritate, anger or distract the professionals from their jobs.

The 'good patient' phenomenon is not exclusive to childbearing women, however the anthropological work of Davis-Floyd (1986) and the qualitative study of Hansen and colleagues (Hansen, Van de Vusse et al. 2001) offer a plausible rationale for why the women in this study planned to become so passive and subdued during their baby's birth. Davis-Floyd (1986) observed that, in response to being ascribed a deferential 'patient' persona by staff, childbearing women attempt to adopt that persona and please their caregivers by fulfilling the expectation that they will be passive and compliant. Some 15 years later Hansen and team (2001) also identified this to be the case in women's birth stories, and subsequently analogised childbearing as a theatrical production with a cast that includes a "star, supporting cast, director and/or producer" (p. 19). These authors found that in their respondents' hospital births, when the health care staff cast itself as the star, the women took a supporting, enabling role. Although these works referred to women in labour, the concepts do transfer to the findings of the current study and help to explain the motivation behind

how the women planned to behave during their scheduled caesarean section.

The lack of information available to women about the emotional side of having a scheduled caesarean section also affected their ability to make meaning of their experience. As already explained, the underlying reason for women's unrest about needing to have a scheduled caesarean section was that they and their social groups held a preference for natural birth. The passivity of the experience, for example, arriving at the hospital at a predetermined time, laying still and quiet on a table, and having their baby 'retrieved' from them did not match these women's construct of giving birth and becoming a mother, and they struggled to work out how to make sense of having a baby in this way. Becoming a woman who had to have a caesarean section was deeply confronting for these women, and it forced them to revise their beliefs and assumptions about it. In addition, women's inability to fulfill their primal need for centrality in their birth experience was also very confronting and confusing.

As discussed previously, childbearing women's need to 'drive' their own birth and know their place in it is known to be of seminal importance (Luyben and Fleming 2005). In addition finding meaning in change is known to be critical for resolving the unrest it causes (Bulman and Wortman 1977; Taylor 1983; Thompson 1985; Affleck and Tennen 1996; Lee, Cohen et al. 2006; Stuckey and Tisdell 2009). Only two papers reporting meaning-making in relation to childbirth could be found, and although neither was specifically concerned with caesarean section, they are informative nonetheless. The first is by Rubin (1984), whose earlier work has already been referenced in this chapter. In this later study, Rubin found that postnatal women placed extremely high value on 'knowing' their experience, and noted the most striking characteristic of maternal behaviour in the early postnatal period to be the silent organisation of thought. The second work is by Callister (2004) who, some twenty years later, confirmed Rubin's (1984) theory to some extent, in that she agreed with the assertion that women across all cultures and in all contexts need to be able to define the meaning of their birth experience. Differently to Rubin, though, Callister (2004) found that women need to share their experience with others to 'know' it, rather than to work through it alone and silently. In her analysis of women's childbirth narratives, Callister (2004) discovered that it was the sharing of their experience that enabled women to make sense and meaning of it, and to integrate it into their life.

In the light of this information, it is possible that the women in the current study were unable to make sense of and integrate their experience of scheduled caesarean section by 10 to 14 weeks postnatal simply because they had no-one to whom they could talk through their experience, or to deliberate its meaning, even though they demonstrated acute recognition of the need to do so. Women sought to explore and contextualise their feelings about needing a scheduled caesarean section, but found little to no opportunity to do so. Unfortunately, despite women's best solo efforts, it would appear that their experience strongly confirms Callister's (2004) theory; being unable to explore their own journey in the light of other women's experiences (either in person or in print) meant they still had not resolved their struggle to accommodate their new reality 10 to 14 weeks after the birth.

In the following section women's experiences of their surgery, where their sense of isolation continued, are explored.

Failing to stay in control in the operating room

According to the women in this study, their inability to determine a meaningful role for themselves in the operating room meant that although they did become inert and disengaged, this did not occur through controlled, conscious effort as they had thought it would. What women described instead was a feeling of becoming involuntarily paralysed, and of being unable to resurface from this state even when their fear or discomfort became extreme. The literature suggests that women's inability to voluntarily revoke their state of inertia could be because of perioperative or perinatal dissociation, and a degree of tonic immobility.

Dissociation is a recognised condition that occurs either during a highly stressful event (when it is known as peritraumatic dissociation), or after one (posttraumatic dissociation). The experience involves "disruption in the usually integrated functions of consciousness, memory, identity or perception of the environment" (American Psychiatric Association 1994, p. 766). Among other manifestations, peritraumatic dissociation may be experienced as fragmentation of the self, reduced awareness of surroundings, and detachment (Bryant 2007, p. 184). The women's descriptions and my observations strongly suggest that this was exactly what was happening to all but one of the women in this study (including two of the 'negative cases', Ginny and Pauline). The exception was Michelle, who was the third 'negative case'.

Similarly, tonic immobility is an acknowledged phenomenon, and is described as an unconditioned response to situations that are perceived as inescapable and that elicit fear (Bovin, Jager-Hyman et al. 2008). First described in 1971 as a predator survival mechanism in prey animals (Gallup, Nash et al. 1971), the response has also subsequently been reported in humans. The experience of tonic immobility includes gross motor inhibition, suppressed vocal behaviour, and fixed unfocused staring (Marx, Forsyth et al. 2008), all of which occurred in the women in the current study. Preliminary work by Heidt, Marx and Forsyth's (2005) demonstrated a strong relationship between tonic immobility and peritraumatic dissociation.

Over the last ten year research concerned with these two phenomena has appeared in the psychology and trauma literature with increasing frequency. Most commonly, this has been in the contexts of violent crime such as sexual assault (see Suarez and Gallup 1979; Galliano, Noble et al. 1993, for example; Fusé, Forsyth et al. 2007; Rocha-Rego, Fiszman et al. 2009) and disaster (as reported by van der Velden, Kleber et al. 2006, among others). Investigative work on peritraumatic dissociation has also featured in the health literature, however in the main, this work has been concerned with sudden-onset and immediately life-threatening health episodes. Ladwig and colleagues' (2002) identified the phenomenon in heart attack victims, for example. More recently, literature pertaining to peritraumatic dissociation in pregnant and childbearing women has also started to appear.

In their investigation into a possible link between perinatal dissociation and postnatal posttraumatic stress, Olde and colleagues (2005) studied 140 Dutch women who had a natural or instrumental vaginal birth as well as those who had a non-elective, emergency or scheduled caesarean section. The research identified that women who reported higher levels of dissociation intrapartum subsequently also reported higher levels of posttraumatic stress symptoms at three months postnatal (p. 137). Unfortunately, the results are not distinguished by birth mode so it is unclear whether the women who had a scheduled caesarean section experienced perinatal peritraumatic dissociation. Regardless, the women's experiences reported in Olde and colleagues' publication closely resembles that of the women in the current study. In contrast however recent work by French investigators Boudou, Séjourné, and Chabrol (2007) found differently. In their study concerning the sequelae of childbirth pain, perinatal distress and perinatal dissociation, Boudou and colleagues reported

the development of postnatal posttraumatic stress to be significantly associated with pain-related distress, but perinatal dissociation was not implicated.

Apart from the three women in Olde and colleagues' (2005) study, there does not appear to be any work concerning perinatal or perioperative peritraumatic dissociation in the context of scheduled caesarean section in the literature to date. The findings of the study reported in this thesis therefore make a significant contribution to knowledge by highlighting that even women who know with absolute certainty what their birth mode will be can experience dissociation during the birth itself.

Mothering in limbo

The final section of the chapter explores how the consequences of becoming redundant and engaging in the intense emotional work of regrouping played out in the early postnatal period. One of the most significant findings of this study was that women clearly articulated a sense of emotional disconnection from their baby on returning from theatre. The analysis identified that these feelings persisted with women continuing to engage in regrouping actions some 10 to 14 weeks after their baby's arrival. In tandem women were also noted to be still working through the meaning of their scheduled caesarean section, specifically the necessity of the procedure, their role within it, and whether they could consider themselves as having given birth. Essentially women were caught in a 'Catch 22' situation, in that they were extremely concerned about their lack of attachment to their baby yet they actively perpetuated this detachment as they persisted in focusing largely on trying to make sense of their birth experience. In the following discussion women's non-involvement in their baby's birth (and the resulting grief and traumatic stress) is explored as the basis of poor or compromised mother-newborn connection. The potential implications of having an emotionally-distant mother for infants' future well-being and development are then considered.

According to the bereavement and trauma literature, women's ongoing preoccupation with their caesarean section may represent a non-resolution of the grief and traumatic stress caused. This work suggests that distraction by a loss or losses is unlikely to abate while a lack of understanding of the loss remains. Stroebe (1992) theorised grief as intensely demanding cognitive work, which was deconstructed by Worden

(1991) to involve a series of tasks. According to Stroebe, the process of loss integration involves a comprehensive restructuring of thoughts about what has been lost and about the changed world in which one now exists, and takes time and effort. Worden suggests that this restructuring has to include accepting the loss as real, absolute and irreversible before one can begin to move on from it, and also acknowledges the process as “something that takes time.” (p.26). Neither author advises how long the process might take though, and in fact Worden warns that one may never accomplish certain or any of the tasks of mourning (1991).

In several classic studies, the emotional state of bereft participants has been found to be disturbed to at least one year post-loss (see for example Parkes 1964; Maddison and Walker 1967). If women’s experiences were conceptualised as a grief process then the assumption can be made that at 10 - 14 weeks post birth women were still very early in the process. The theoretical works of Bowlby (2005) and Parkes (1970) shed further light on this aspect of women’s experience. Both wrote extensively about how bereft people engage in a ‘search’ for a lost or stolen meaningful object that is often all-consuming. It may have been the case that women’s persistent and consuming reviewing of their scheduled caesarean section represented their search for their lost objects - their natural birth experience, their role as a birthing woman and their connection to their baby.

The emotional detachment from their infant that the women expressed may also have been a symptom of traumatic stress. Ballard and colleagues’ (1995) study investigating post-traumatic stress in new mothers found that women who were symptomatic of the condition exhibited a marked lack of connection to their baby. Reynolds (1997) also reported women who were birth-traumatised to feel estranged from their newborn.

The implications for newborns of having an emotionally unavailable mother are serious. Babies’ sense of safety and security is known to be threatened when unwell, physically hurt, frightened or otherwise emotionally upset (Benoit 2004). The return to a state of safety and security is entirely dependent upon how another to whom they are emotionally attached, usually their mother, responds (Bowlby 1982). The way an infant’s personal distress is responded to by their attachment figure (mother) determines how that child’s psychological, social, emotional and behavioural

development ensues (Benoit 2004). Through observational research, Ainsworth (1979) and Main and Solomon (1986) identified four patterns of attachment between children and their mother or other solace figure, depending on how the caregiver responded to the child over a number of episodes of distress. Briefly, infants of mothers who consistently responded to their distress in a timely, attentive and comforting manner were found to have developed a 'secure' attachment pattern while those whose distress elicited an inconsistent response demonstrated an 'ambivalent/resistant' pattern of behaviour. Matas, Arend and Sroufe (1978) identified that two year-old children who had been earlier identified as secure were demonstrably more confident, cooperative and flexible in challenging situations than children who were not. Infants whose solace figure was consistently dismissive and intolerant of their distress were observed to have developed an avoidant behaviour pattern, and those whose solace figure was consistently frightening, punishing and/or violent in response to their distress became behaviourally 'disorganised' in times of need (Ainsworth, Blehar et al. 1978; Main and Solomon 1986). Longitudinal studies with animals and humans have found all three 'insecure' attachment patterns to herald suboptimal child development in many aspects.

Pedersen's (2004) extensive review of animal and human research concerning the quality of maternal care also drew some worrying conclusions about the influence of maternal disregard or neglect in early life. The research reviewed reported that the quantity and quality of maternal care received during infancy determines adult social competence, ability to cope with stress, aggressiveness, and even preference for addictive substances. Pedersen's (2004) review also indicated an inter-generational 'on-cost' of maternal indifference for female infants: the development of neurochemical systems within the brain that regulate mothering, aggression and other types of social behaviour, such as the oxytocin and vasopressin systems, are apparently strongly affected by the degree of nurturing received during infancy. More recently Korean researchers Kwak and colleagues (2009), have recently discovered an association between being distanced by or from their mother and the development of hyperactivity and anxious behaviour in the offspring of rats.

In addition longitudinal studies following the ability to regulate and control negative emotions, stress, tendencies towards opposing authority, aggression, hostility and coerciveness, overall psychological wellbeing at 17 years of age and vulnerability to

altered states of mind in early adulthood have found that these outcomes are also dependent on one's attachment style (Speltz, Greenberg et al. 1990; Greenberg, Speltz et al. 1993; Splanger and Grossmann 1993; Hertsgaard, Gunnar et al. 1995; Solomon, George et al. 1995; Lyons-Ruth and Block 1996; Lyons-Ruth, Easterbrooks et al. 1997; Carlson 1998; Hesse and van Ijzendoorn 1998; van Ijzendoorn, Schuengel et al. 1999). Unsurprisingly, given the significant part it plays in child development, the role of attachment figure has been argued as the most important role a mother plays in an infant's life (Dozier, Stovall et al. 1999; Greenberg 1999; Green and Goldwyn 2002). The sense of detachment women felt at 10-14 weeks after the birth of their baby is thus a finding that should raise alarm bells among maternity professionals and consumers alike.

Summary

In the first part of this chapter, the redundancy women experienced when faced with an unexpectedly and unwanted scheduled caesarean section has been discussed in the context of the current literature. The problem was postulated to represent an enforced change of course that meant the loss of women's expectations for childbearing. Each particular expectation that was lost to women, and the impact of those losses – specifically grief and a form of traumatic stress, were considered in the context of the existing literature.

In part two, the process women undertook in response to their redundancy was discussed in the context of the literature on change, loss, grief and mourning. Parkes' (1971) Psychosocial Transition Theory was proposed as a likely explanation for why women responded to the need for caesarean section in the way they did. The factors that moderated women's ability to transition redundancy were also explored. The implications for women of existing between two dichotomous childbearing philosophies – their own Feminist perspective and the hospital's Paternalist view – in relation to their capacity to transition the enforced change to their childbearing plans was also discussed.

Despite extensive searches of the scientific literature, it seems that the entire trajectory from hearing of the decision of an unwanted caesarean to 10 – 14 weeks postnatal has not previously been reported either in Australian women or those of other nationalities or cultures. Certain aspects of women's experience were, however,

found in the literature of other disciplines, and when the study findings are considered in the context of this work, they make a substantial addition to our understanding of the essential constituents of a fulfilling childbearing experience. The work in this thesis also contributes to our knowledge of how an unfulfilling childbearing experience impacts on women's psyche and feeling of connection to her newborn, and provides new insights into how the prevailing maternity care paradigm can diminish women's experience of childbearing. More than ever before, this research demonstrates the fundamental need for women to be central in and satisfied with their childbearing, and of the emotional and psychological price they pay when they are not. This work also demonstrates that women, unlike the maternity health care professionals providing care, struggle to readily accept the need to birth in a different way than originally anticipated.

The findings and surrounding evidence clearly convey that presently, the emotional care of women who become in need of an unwanted scheduled caesarean section is inadequate. Women's need to grieve the losses inherent in the change of childbearing course they must endure is not recognised or facilitated. Neither is the opportunity provided for women to explore the meaning of the experience of scheduled caesarean section, both to them and for them. Perhaps most fundamentally, women are not enabled to remain the centre, or the 'star', of their own childbearing experience.

The next and final chapter of this thesis presents arguments that may go some way to addressing the gaps highlighted by this work and improve the quality of service delivery to this group of maternity care consumers.

Chapter 8

Future Directions and Final Thoughts

Introduction

The study reported in this thesis provides new insights into how women experience an unexpected and unwanted scheduled caesarean section. This research also confirms other theoretical and scientific work that associates an unsatisfying birth experience with maternity service design and delivery, as well as with a myriad of future health, well-being and functioning difficulties for childbearing women. Contrary to the apparent widespread perception of health professionals, women who become unexpectedly in need of an unwanted caesarean section are unlikely to just accept the decision. Additionally, they may become ‘second class’ maternity care consumers due to non-recognition and subsequent neglect of their emotional needs. In this context, women are likely to find it difficult to emotionally move past the decision and the experience to become fully engaged and focused mothers.

On a positive note, the valuable information gleaned about the essential care needs of this group of women suggests many ways in which maternity services might significantly contribute to reducing the likelihood of women suffering childbirth non-fulfilment, dissatisfaction and regret. This final chapter makes recommendations to forestall such outcomes and offers suggestions for maternity care practice and maternity service design, for the education of maternity care personnel, and for further research in this area. Before recommendations are made, however, reviews of the study and the theory are provided, and the strengths and limitations of this work are reported.

Overview of the study

The primary aim of the study reported in this thesis was to discover how women experienced and processed anticipating and giving birth by a caesarean section unexpectedly scheduled during pregnancy for a health reason. The secondary aim was to locate this research within existing knowledge. Four specific research questions were asked, including i) how do women **experience** the recommendation and subsequent decision to schedule a caesarean section, and the procedure itself?; ii)

how do women **process** needing and having a necessary scheduled caesarean section?; iii) how do women reflect upon their antenatal and birth experiences? and iv) what factors, if any, facilitate the way in which women experience and process needing, having and moving on from a necessary scheduled caesarean section? The intended product of the study was a substantive explanation of women's experience of an unexpected scheduled caesarean section.

Grounded Theory of the Glaserian variant was the chosen methodology for the research. This methodological selection was justified on the basis of information gleaned from women during a previous study (Bayes, Fenwick et al. 2008; Fenwick, Gamble et al. 2009), wherein it appeared that women who had to be booked for a caesarean part-way through pregnancy experienced having a baby quite differently to other childbearing women. It also seemed that their experience went seemingly unrecognised and unacknowledged by their caregivers. The apparent near-absence in the literature of evidence about women's experience of having a baby this way confirmed this was a subject worthy of inquiry. The rising scheduled caesarean section rate in Australia provided further justification.

Two outcomes of the study were anticipated. The first was that this group of women's childbearing problems and care needs would be determined. The second was that a body of knowledge about this experience would become available for the development of woman-centred, evidence-based clinical policy and guidelines.

The methods utilised in the current study render its findings particularly strong. Firstly, a relatively large number of participants as well as the collection of five different data sets provided a total of 242 hours and five minutes of data. Secondly, systematic and thorough analysis of the data and continual memoing increase the likelihood that the findings and the theory were trustworthy. I also involved other people and groups who had experience of scheduled caesarean section at various stages through the development of the theory, to 'test out' if the findings 'fit'. Analysis of the data collected in this study did, as anticipated, result in the development of a substantive theory of these women's experiences. The theory was titled **Becoming Redundant**.

Review of the theory

The theory of **Becoming Redundant** explains the core problem that needing a scheduled caesarean section presented women with (**Being Made Redundant**) as well as the psychosocial process (**Regrouping**) they undertook to try and deal with it.

The women in this study embarked on pregnancy with the expectation that their birth experience would be natural and with the assumption that the birth of their baby was their responsibility. The thought that they might need a caesarean section never crossed the women's minds and, typically, they considered it to be something that happened to other 'less resilient', 'less capable' women. When the women were advised that they would no longer be able to give birth naturally they described being cruelly robbed of something very precious. As a consequence, women experienced a range of immediate and unconditioned responses including shock, disbelief, anger, deep sadness, and fear. They also talked of feeling physically 'emptied', and of being overcome by dizziness on hearing the news.

Almost immediately women heard the news, they became caught up in an all-consuming cycle of reaction and action. This involved attempting to verify that they really did need the procedure, that their health condition did mean they wouldn't be able to give birth naturally, and that caesarean section was definitely happening to them. The activities that women engaged in included consulting with other health professionals and lay people (both in person and on the internet), telling as many people as they could of the decision, and searching for any information that would help prepare them for the experience of the procedure.

Following the decision to schedule a caesarean section, women perceived a change in the nature of their interactions with maternity caregivers. Midwives and doctors became noticeably less warm, more distant and more 'clinical'. Women's opinions about their care or experience were no longer sought, and they were no longer involved in meaningful decision-making. The women articulated coming to feel like passive recipients of care, whereas before they considered themselves to have been actively involved participants. Women sensed a change in status from active participant in their baby's birth to passive bystander. The focus of care was shifted from the woman to the surgical procedure.

This exclusion of women from participating in, or having responsibility for, their childbearing manifested itself in a number of practical ways. These included women being unwelcome to attend childbirth preparation classes, the non-provision of a visit to the area where the birth would take place (the operating theatre), and the lack of opportunity to complete a birth plan. As well as making women feel like 'second-class citizens', this shift of caregivers' focus meant that women were never given an opportunity to disclose or explore their feelings about needing a caesarean section.

Being relegated to the periphery of their caregivers' attention led women to the realisation that they could not expect any assistance from the hospital to integrate the decision or prepare for the procedure. The lack of available written or audio-visual material about the procedure, either at the hospital or elsewhere, served to confirm they were 'on their own'. Recognising that they were essentially going to have to deal with their new situation alone and 'in the dark' led the women to mentally construct and rehearse what having a scheduled caesarean section would be like. Participants also expended energy on working out a 'positive spin' on having a caesarean section, on figuring out how it could be a good, fulfilling experience, and on deciding what they could possibly usefully contribute. In the end, the only valuable role women felt they could ascribe to themselves during the surgery was to 'become invisible' - inert and silent - while their caesarean section was underway. This was explained as a way of ensuring they didn't disturb the surgeon or disrupt the procedure in any way. Women also conjectured that although they couldn't actively participate in the birth, they could become their baby's mother and be there for him or her as soon as he or she was delivered.

Women's increasing sense of non-involvement in their childbearing experience peaked on the day of their caesarean section. Throughout the day, women were objectified through being identified either as a "caesar" [sic] or their obstetric health condition, and were further depersonalised through being referred to as a number. The lack of holistic care women experienced continued into the operating theatre, wherein the attention of caregivers was entirely upon women's physiology and the procedure. When women first entered the operating room, they did succeed in invoking the state of 'suspended animation' that they had planned prenatally. As their caesarean section began they were able to maintain a state of silent calm, despite feeling frightened and anxious. A short time after the procedure started, however,

powerful unconditioned physical responses such as shaking, altering consciousness and vomiting threatened to overwhelm them. Women struggled to simultaneously manage to subdue their responses whilst maintaining their role as a model patient. Unfortunately, when women tried to connect with someone, they found themselves effectively paralysed and unable to speak. When eventually they were indeed overcome by their various physical symptoms, women said they felt ashamed, guilty and a 'failure' for being unable to exercise better self-control.

Far from their original expectations of how their baby's birth day would be, women did not feel special, revered or central in their caesarean section. Instead they felt disengaged, forgotten, frightened, bewildered, panic-stricken and stressed. Moreover, although each woman felt strongly connected to and deeply maternal towards their newborn at the moment of birth, and yearned to have their baby in their arms, hospital protocol prevented them from doing so. In most cases, the newborn was taken to the postnatal ward only minutes after delivery and being briefly shown to or held by their mother, and so women could not fulfil their maternal instincts or take up their maternal role immediately as they had hoped they would.

By 10 to 14 weeks postnatal women were resentful and expressed feeling 'short-changed'. The almost immediate separation from their newborn eventuated in women perceiving they had lost their very strong initial connection to the baby. This was a key factor in women's dissatisfaction and distress with the experience. Women had also, at this point in time, still not satisfactorily resolved the news that they couldn't give birth naturally, and that a scheduled caesarean section truly was their only option. Neither were women certain that their lack of involvement in their baby's birth was necessary, or that the inert role they had constructed for themselves for the intrapartum (intra-operative) period was right for them. Additionally, many of the women continued to feel they were treated as a 'persona non grata', only now it was by other mothers who had given birth naturally.

Having persistent unresolved questions, doubts and feelings about having a scheduled caesarean section meant that rather than fully engaging with their baby in the early postnatal weeks, women instead found themselves absorbed by trying to settle their doubts about the validity, meaning and implications of the procedure. A significant amount of this time was spent trying to recapture the lost connection to

the baby. Ironically, the time and energy women spent in reflection only distracted them from their infant even further. Women recognised this only too well, but were powerless to do anything about it, for even when they consciously tried not to think about their caesarean section, they were ‘nagged’ by thoughts of it. Four moderating factors were found in the data to explain why women experienced and processed their scheduled caesarean section in the way they did.

The first of these moderating factors was related to women’s pre-pregnancy assumptions. On becoming pregnant, women expected that they would have a straightforward, spontaneous labour and an uneventful vaginal birth “under their own steam”. For the majority, their views about and hopes for their baby’s birth had been engendered and refined over the preceding years. Never had they considered the possibility of medical intervention, and they framed caesarean section as something that happened to other less committed and less capable women. As a result, needing a caesarean section shattered women’s worldview, which explains why their response to the decision was one of deep shock, disbelief and loss.

Time also moderated women’s experience. In comparison to the length of time over which women had formulated their original ideas about childbirth, the amount of time available for processing all that having a scheduled caesarean section meant and would entail was very limited. As the day “hurtled” towards them, women tried desperately to prepare for the procedure. Unfortunately, although having more time was better than having less, ultimately the time available proved inadequate regardless of whether there were days or weeks before women’s caesarean section, and they described feeling their preparations were incomplete.

The third factor that moderated women’s experience was the presence of a sterile surgical drape hung in front of women’s faces during their caesarean section. Despite feeling no longer involved in their caesarean section and only very superficially prepared for it, the women maintained a belief that they would still be the centre of attention during their caesarean section. They also presumed that they would be recognised and respected as a mother, and that responsibility for their baby would be restored to them immediately their infant was delivered. Unfortunately, because the operating theatre routine included hanging a large drape that effectively screened women off from the procedure, they were not really ‘seen’ or acknowledged at all by

the majority of the other people in the room, who were ‘on the other side’. The hospital routine of sending the baby (along with his or her other parent/carer) to the postnatal ward a short time after birth whilst women remained in the operating theatre department also meant that women’s transition to motherhood was neither acknowledged or honoured, nor responsibility for their baby returned to them, until they were reunited with their baby on the postnatal ward at least an hour after the birth.

The fourth and final factor that moderated women’s experience of caesarean section was the hospital’s ‘takeover’ of all responsibility for the birth and for the baby from the woman. This entailed stripping all aspects of women’s involvement in their own childbearing experience, and re-locating them to the position of passive bystander.

This research makes a significant and original contribution not only to the maternity literature, but to the body of work concerning change transition. The findings of the research are anticipated to be of interest to maternity care and ‘allied’ health clinicians, researchers, educators, policy and guideline developers and consumers. The theory of **Becoming Redundant** provides maternity care professionals, academics and consumers with previously unknown information about how women might experience, manage and be affected by unforeseen and unwelcome change during the childbearing episode. The new knowledge reported in this thesis about the conditions influencing women’s experience of caesarean section is likely to be of particular value to maternity service designers, as is the new information detailing the legacy that non-transition of an unforeseen, unwelcome and un-facilitated change during childbearing leaves women with. Whilst the findings of this study contribute significantly to the body of knowledge, there are however limitations to the study, and by extension to the emergent theory, that must be considered.

Limitations

Firstly, the inclusion criteria for this study meant that only women who could speak conversational English and were over 18 years of age could participate. While the inclusion of women of several different ethnic origins and cultural backgrounds as well as three negative cases enabled the theory of becoming redundant to be tested to a degree, the inclusion of women younger than 18 years old and those unable to speak English would perhaps have been useful in this regard.

Secondly, although this study sought to include the views of maternity health care professionals and women's partners to contextualise the experience of women anticipating and having a scheduled caesarean section, this particular data was not collected and analysed to the point of saturation and therefore can not be considered representative of either the staff at the study site or of all the women's partners.

Third, despite using recommended strategies to help me 'blend in' (Turnock and Gibson 2001) to the operating theatre environment during participants' caesarean sections, it was evident after my eleventh attendance that my presence was having an effect on the behaviour and practices of operating room staff. On reflection, perhaps the use of discreetly-placed audio-visual recording equipment instead (Spiers 2004) would have both allowed more women's experiences to be observed, and would have allowed the capture of a greater amount of 'authentic' data.

Lastly, although I made every effort to acknowledge and set aside my assumptions about how women might experience an unwanted and unexpected caesarean section, I must concede that there is a possibility that my analysis of the data was coloured by my experience as a midwife, as a woman who has given birth, and as a friend of women who have had caesarean sections. It is my hope that as far as possible, the influence of my experiences was erased through frequent 'member checking' and regular review of my analysis decision-making in conjunction with my supervisors, however it is impossible to know how successful those measures were.

Despite these limitations, the remit of this study, which was to generate a theory of how this group of women experienced an unwanted caesarean section scheduled for them during pregnancy because of an emergent health reason, was fulfilled. As a consequence, new knowledge has been generated about this experience that forms a useful addition to the existing body of work concerning this phenomenon. The implications of this new knowledge for maternity services and for academic facilities are now offered.

Recommendations

When considered in the light of the contextualising literature, the emergent theory of **Becoming Redundant** has a number of implications for maternity care philosophy, design and practice, for the education of maternity care professionals, and for future

research. These are now presented in the form of recommendations for each of these domains.

Maternity care philosophy, design and practice

The maternity care of women who must have a scheduled caesarean section is seemingly constructed around a perception of the procedure as a routine everyday surgical operation. In this paradigm, the procedure itself is the ‘star of the show’ while the woman is passive and non-contributory. The findings of this study demonstrate that for women who perceive childbearing to be a unique, deeply emotional and spiritual transformative experience that is ‘driven by’ and centred around the mother-baby dyad, hospital care within an opposite philosophy engenders disappointment, isolation, humiliation, disempowerment and possibly a form of trauma. It is clear that a number of fundamental changes to maternity care delivery and practices are imperative if women having an unexpected and unwanted scheduled caesarean section are to be protected from feeling redundant in or unnecessarily introspective about their childbearing experience.

Philosophy of care

Of key importance is a cultural shift in the way maternity services perceive the procedure. To increase the likelihood that women will feel central in and satisfied with a ‘necessary’ but unwelcome caesarean section, the procedure must be reframed as a birth rather than an operation. Inherent in this is a need for professionals involved in these women’s care to shift their focus away from the procedure and onto the woman and her connection to her baby. It is thus recommended that maternity services acknowledge and promote the view that each scheduled caesarean section is regarded as a unique birth event rather than as a routine surgical procedure. Practical ways in which services might achieve this include the development of policies and clinical guidelines which convey scheduled caesarean section as an individualised, personal and woman-centred experience. The use of, for example, ‘woman’ rather than ‘patient’, ‘birth’ rather than ‘surgery’ and ‘post-natal’ rather than ‘post-operative’ would impart a clear message to this end. It might also follow that all documentation and communications concerning caesarean section are so worded. The findings of the study suggest a number of practical measures and initiatives that maternity services and midwives can introduce that, individually and together, are

likely to foster such a cultural shift.

Care design and delivery

It is likely that the experiences of the women in this study could have been vastly improved had their care been constructed differently. Continuity of midwifery models of maternity care that enable staff, women and their partners to establish and maintain a meaningful relationship throughout the childbearing episode are available, and have repeatedly demonstrated better outcomes than the traditional institutional approach. Examples of these models include 'team', 'caseload'/'one-to-one' and 'group practice' midwifery (Homer, Brodie et al. 2008). Randomised controlled trials (RCTs) have consistently found that, internationally, continuity of midwifery carer report increased satisfaction with care and with the birth experience for women (Flint, Poulengeris et al. 1989; MacVicar, Dobbie et al. 1993; Kenny, Brodie et al. 1994; Rowley, Hensley et al. 1995), improved rates of mother/baby attachment or bonding (McCourt and Page 1996; SPCERH 2001), improved rates of long-term breastfeeding, and reduced rates of postnatal depression (Fisher, Astbury et al. 1997; Littlewood and McHugh 1997; Hildingsson and Haggstrom 1999). Outside of introducing a more woman-centred model of maternity care, however, there are a number of relatively simple measures that midwives and other maternity care professionals could initiate that together, might improve women's experience of scheduled caesarean section.

Perhaps most importantly, midwives could choose to afford women the time and space within care episodes to disclose and explore their feelings about needing a scheduled caesarean section. The findings of this study suggest that women would greatly appreciate even a brief acknowledgement from maternity care professionals that needing a caesarean section might cause or have caused her to feel cheated, bereft and/or traumatised. What was also apparent was that such an acknowledgment would make an enormous difference in reducing women's sense of isolation in their disappointment or grief. If time for further exploration and discussion of those feelings is limited during women's appointments, or if the context is not conducive, the provision of information about resources either within or external to the care setting that are concerned with supporting women to deal with needing a caesarean section would also be highly beneficial. The Western Australian-based consumer-led service 'Birthrites Inc' (<http://www.birthrites.org/>) is one such external resource.

Another relatively simple initiative that would be beneficial to this group of women would be to schedule caesarean section for no less than a week after the decision is made, as long as the woman's and/or the baby's health condition allows. This measure would enable women at least some time to begin to adjust to the decision, and to make their preparations for birthing in a radically different way than they had expected. The amount of time available to women between learning of the need for the caesarean and having it certainly affected how well they were able to integrate the decision and prepare for the procedure. Currently, the recommended timing of scheduled caesarean section is at least 39 completed weeks of pregnancy unless a compelling for earlier intervention exists or emerges (see for example Alderdice, McCall et al. 1995; National Collaborating Centre for Women's and Children's Health 2004). The majority of the scheduled caesarean sections in the current study, however, were performed between 38 and 39 weeks gestation, despite the fact that the women and fetuses were otherwise well and the need to intervene was not urgent.

Delaying scheduled caesarean section to 39 weeks or beyond has been calculated to increase the *unscheduled* caesarean section rate by up to 10 percent. This number reflects the amount of women who, based on historical data, are likely to go into labour prior to 39 weeks (National Collaborating Centre for Women's and Children's Health 2004). This potential increase in demand for unscheduled caesarean section is, anecdotally, frequently cited by smaller and more remote maternity services as a reason not to defer scheduled caesarean section beyond 38 weeks. Given the likely myriad short and long term benefits afforded to women and infants by delaying the procedure to at least 39 weeks, however, it is incumbent upon all maternity services to find a way to accommodate the theoretical increase in out-of-hours caesareans and to adopt this standard.

Facilitating women's need to complete essential childbirth preparation 'rites' also has the potential to improve women's experience of scheduled caesarean section. Providing an exclusive caesarean section-specific antenatal education session for those who know they will be having the procedure, conducting a tour of the operating theatre, and encouraging women to develop a birth plan would all be invaluable in enabling women to transition the change that has befallen them, and to be as prepared for their caesarean section as possible. Each of these initiatives has been adopted in the hospital where I am employed, and further details of their

development, introduction and subsequent evaluation are provided in the epilogue to this thesis.

In the operating theatre, lowering the drape that is hung in front of women's faces during the caesarean section procedure would have the effect of both enabling women to be and feel part of the event, and of ensuring the woman remains in the view of the staff. As discussed earlier, the use of a screening drape during caesarean section apparently has no basis in science. In this study the presence of such a screen was demonstrated to be extremely detrimental in that it emphatically excluded women from their baby's birth. Conversely, the absence of the drape in Michelle's 'maternal-assisted' caesarean section (reported in Chapter Six) undoubtedly facilitated her involvement in her birth experience. Having the woman visible to the operating room staff might also make it more likely that the baby is moved directly to his or her mother's embrace rather than a neonatologist's once born. For well neonates who are born vaginally, many midwives advocate that the routine care measures such as Apgar testing, and baby labelling be carried out while the baby is on the woman's chest to facilitate positive mother-baby dyad attachment. It is also possible for this to occur in the case of caesarean section. For the neonate who is unwell and needs supportive care, locating the resuscitation/examination cot within sight of his or her mother is essential if the woman is not to lament 'lost' moments of her baby's early life. Measures such as these would communicate clearly to women that their crucial need for unbroken contact with their baby after birth is recognised, and that enabling them to stay together wherever possible is valued for the part this plays in fostering a positive, strong mother-baby relationship.

Education of maternity care professionals

The above recommendations can only be facilitated by clinicians who have an awareness of the salient issues. To this end, it is recommended that the findings of this study are included in both preparatory and continuing education of maternity health professionals. It is important that clinicians and student working in maternity settings be educated in a way that reflects caesarean section as a unique woman-centred birth experience rather than as a routine surgical procedure. This should be within a context that promotes normal birth and works to reduce the primary caesarean section rate. It is also necessary to promote nursing, medical and midwifery students' and practitioners' appreciation of how unexpected and

unwelcome change during childbearing can impact on women's psyche. Specifically, the promotion of awareness and knowledge in three areas is recommended.

Women's primal need for centrality in and command over their baby's birth

There is a need to foster and regularly renew an appreciation among learning and practising maternity health care professionals of birthing women's need for centrality in and command of – or at least a consultative role in - their baby's birth experience regardless of how the baby is born. Promoting an awareness of the short- and long-term biopsychosocial implications for women, babies, families and, ultimately, communities of an unfulfilling and 'disconnected' maternal birth experience are also of great importance.

Issues of power and control in maternity settings

It is of fundamental importance, at an early stage in the education of future maternity health care professionals, that an appreciation of the philosophical paradigms within which the disciplines of nursing, medicine and midwifery practice is clearly imparted. Likewise, it is also essential that emerging and practising maternity care professionals have an understanding that although not all, the majority of women who utilise maternity services are likely to subscribe to a feministic approach to childbearing. Essentially, for women to 'do well' in childbearing, their innate knowledge related to both needing centrality in the birthing event, and remaining in unbroken contact with their baby must be respected and supported if we are to return them to their communities in a state of biopsychosocial wellness.

Breaking bad news, the grief response and the facilitation of change

Arguably, given that one third of childbearing women in Australia currently have a caesarean section, the development of knowledge and skills related to breaking bad news to women should perhaps be afforded the same importance as other mandatory competencies related to safe and effective maternity care. It is recognised that communicating 'bad news' is known to be difficult and stressful for health care professionals in all settings (see Zakrzewski, Ho et al. 2008, for example; Parker, Ross et al. 2010), and there is a body of work reporting a variety of strategies for skill development in this area in the literature. Faulkner (1998) developed a very practical flowchart, and advocates the need to "fire a warning shot" before disclosing information that is likely to be shocking. More recently, Szmilowicz and colleagues

(2010) found a short residential educational retreat helpful in improving newly-qualified doctors' skills in this area, while Bowyer and team (2010) reported 'mixed reality simulation' exercises to be effective with medical students. Predominantly this work is found in the medical literature, probably because breaking bad news is commonly considered to be the responsibility of doctors. As primary health practitioners, however, midwives might also benefit from developing these skills. Similarly, skills for enabling women to express grief or traumatic stress in response to the unwelcome and upsetting news that they will need a caesarean section are necessary.

Opportunities for imparting this knowledge to students and practitioners occur regularly; initial orientation of new employees to a maternity health service setting, 'in-service' sessions, and specifically-themed education days, as well as university classrooms and 'e-learning' environments all offer potential forums for this information to be communicated.

Future research

Much new information emerged from the study reported in this thesis; however the findings also suggested a number of new areas for future investigation. Although women's plans for their future childbearing were not specifically elicited during the current study, evidence was certainly found in the data to suggest they had begun to reframe scheduled caesarean section, and to minimise its impact by "looking for the positives" in it. It is clear in the grief and trauma literature that until the reality of a loss is acknowledged and the search for its meaning is completed, the bereft person will not be able to move on from it. It is important to further investigate and confirm whether in fact it is grief and traumatic stress that is suffered by women whose childbearing course changes for what they consider to be the worse. Arguably, it is also vital to determine whether women's distraction from their infant occurs in utero as well as in the early postnatal weeks. This need is particularly pressing because of the serious deleterious effects that suboptimal maternal 'attending' is known to have on infant development (see Sorce and Emde 1981, for example). Many other possibilities for future research emerged from this study, however five key areas emerged as perhaps most important. There is a need for studies to:

- Determine the incidence of peritraumatic dissociation, tonic immobility, and

posttraumatic stress experienced by women undergoing necessary scheduled caesarean section, utilising valid and reliable measures such as the Peritraumatic Dissociative Experiences Questionnaire (Marshall, Orlando et al. 2002), the Tonic Immobility Scale (Forsyth, Marx et al. 2000) and the Posttraumatic Stress Diagnostic Scale (Foa, Cashman et al. 1997). These instruments have not seemingly previously been utilised in a maternity care context. It is therefore likely that research in this area would be groundbreaking and holds the potential for opening up a new body of knowledge in this previously unexplored area.

- Investigate the serum oxytocin and cortisol levels of women and newborns who are separated during the first hour after scheduled caesarean section in comparison to mother-baby dyads who remain together after the procedure.
- Compare the effect on women's experience of scheduled caesarean section of having/not having a screen erect in front of their face during the procedure. Potential outcome variables that could be compared include childbirth satisfaction, levels of maternal anxiety and maternal depression, and maternal-infant attachment type.
- Assess the effect of a continuity of midwifery model of maternity care, for example 'caseload' or 'group practice' midwifery, on the childbearing experience and biopsychosocial outcomes (such as childbirth satisfaction, levels of maternal anxiety and maternal depression, and maternal-infant attachment type) of women scheduled for a caesarean section during pregnancy, and
- Explore the impact of providing women scheduled for a caesarean section with a dedicated antenatal class, a 'tour' of the operating department and the opportunity to complete a birth plan.

In addition, the development and testing of an educational awareness program would also be extremely valuable, as would a study focusing on the experiences and care needs of the partners of women scheduled for a caesarean section.

Concluding remarks

The intended outcome of the study reported in this thesis, which was a substantive theory about how women experience an unforeseen and unwelcome caesarean section that is scheduled during pregnancy, has been achieved. Presently, one quarter of Australian childbearing women per annum have a caesarean section scheduled during their pregnancy for an emergent health reasons, and in Western Australia, the number is nearer to one-third. Trends over the last two decades reflect that this rate is rising. The evidence strongly indicates, though, that most women enter into pregnancy expecting and wanting to give birth naturally. While a body of research exists that accounts for selected aspects of how women experience unexpected and unwanted caesarean section, the phenomenon has not previously been described in depth.

The investigation was conducted using the Glaserian version of Grounded Theory methodology. Twenty eight pregnant women who had been anticipating giving birth naturally, but who had been recently advised that they would need to deliver by caesarean section, participated in the study. Three of the participants represented 'negative cases'. Multiple forms of data were collected, including semi-structured in-depth interviews with the women, non-participant observations of women's behaviours and interactions in the operating theatre (including situation maps, written notes and pencil sketches), semi-structured interviews with participant women's partners and with maternity health care professionals, and field notes.

For the women in this study, unexpectedly needing and having a caesarean section was a frightening and disempowering experience that shattered long held expectations and triggered a sense of becoming redundant as a childbearing woman. Becoming no longer able to give birth naturally meant that women lost a great many aspects of their childbearing experience, perhaps most importantly of which was their own centrality. All of the women set about trying to recapture this and their other losses where they could; however a number of factors hampered their ability to deal with and transition wholly to their new reality. Consequently, when they were interviewed between 10 and 14 after their caesarean section, women reported feeling cognitively and emotionally 'stuck' in their childbearing experience. The energy and attention that women felt they should have been focusing on their baby was instead

being spent on trying to work out what had happened to them.

The findings of this investigation have important implications for the care of childbearing women. The disappointment, grief and/or traumatic stress which are likely to arise for a women when her childbearing expectations can no longer be fulfilled must be anticipated, recognised, acknowledged and forestalled where possible. For women to integrate and move on from their childbirth experience and become fully engaged in motherhood, those who have had to 'change track' must be afforded the time, space and support to explore the meaning of the change, to fully mourn what they lose because of it, and to recapture their losses to the greatest extent possible.

On a personal note, conducting this research and writing this thesis has been one of the most enjoyable, enthralling - and challenging - experiences of my life. It has led me to examine my own attitudes towards women's experience of pregnancy and birthing, and my own midwifery practice has changed significantly because of it. I have been humbled by the candour of the women, their partners and the maternity care professionals who agreed to participate in this study as they shared their most intimate secrets with me. I now have friendships I would never have otherwise made as a result of conducting this study.

When I embarked on this study and began to realise that women scheduled for a caesarean section became redundant, felt 'removed' from their baby's birth, and had no part to play in it, I was hopeful that the findings would eventuate in positive changes to their care. I could not, however, have imagined that these changes would have been initiated as soon or as effectively as they were, and that has perhaps been my greatest reward for this endeavour. The changes to clinical practice that have resulted from this study are now described in the epilogue to this thesis.

Epilogue

The Implementation of Clinical Initiatives to Improve Women's Experience of Scheduled Caesarean Section

Once a number of key clinicians in the hospital where this research was conducted became aware that this group of women's care could be improved, they moved swiftly to initiate changes. These changes were to ensure that women could both access the information they may need to accommodate the decision for a caesarean section, and to return them to the centre of their baby's birth event. The service improvements included the introduction of a 'Planning a Positive Caesarean' antenatal class, a tour of the operating theatre, a scheduled caesarean section birth plan pro-forma, and a ward visit in the early postnatal period by a member of a dedicated small team of midwives. A number of clinical practice guidelines related to the care of this group of women while they are in the operating department were also revised to reflect a view of caesarean section as a birth, not an operation.

Among the findings of this study was the discovery that women booked for an unwanted and unexpected caesarean section during their pregnancy had no opportunity to explore their feelings about the decision or to learn about the procedure. This research also revealed that being unable to attend childbirth preparation classes or tour the area where they would birth contributed to women feeling 'second class'. On becoming aware of these specific findings, the hospital's Antenatal Education department developed and introduced a class for this group of consumers that they hoped would address these issues. Now all women who are booked to have a caesarean section are invited, along with their partner or support person, to attend a one-off three hour long Saturday class when they are around 34-36 weeks pregnant. While there is a loose framework around which each class is constructed, the specific content is determined by the needs of each small attending group. The class was developed in this way to enable women's individual needs to be met as far as possible; this was in direct response to the finding in this research that women were unhappy that they were treated like just a case on a list and as if they

were undergoing a routine clinical procedure. The three-hour class is divided into several components with different aims. These include time for women to share how they are feeling about having a scheduled caesarean section and hear how others are feeling, time for a guided discussion about what the experience of the procedure might be like, a birth plan completion session, and a tour of the operating theatre. Part of the reason for holding the class on Saturdays is that there are no scheduled procedures in the operating rooms on weekends, and so the women and their partners in the 'Planning a Positive Caesarean' session can take as long as they wish to explore all the areas and the equipment, and acclimatise. The midwives who facilitate these classes report that they are consistently evaluated extremely positively by participants, and that informal feedback from women who have attended suggests the class is very helpful for increasing confidence and reducing anxiety and fear. The midwife who spearheaded the development of this class successfully submitted a poster presentation abstract for the 2009 Australian College of Midwives' Conference (Nunan, Bayes et al. 2009).

Following extensive interdisciplinary and community consultation, a birth plan for women booked to have a caesarean section was also developed from the findings of this study. The form was piloted and audited in early 2008, and has now been adopted as part of usual care. All women who are booked for a caesarean section are now provided with a 'Scheduled Caesarean Section Birth Plan' template (see Appendix 7), either in the Planning a Positive Caesarean class or at the pre-admission visit that they attend in the week before their caesarean section. There are nine option items on the birth plan that directly reflect the findings of this study, and there is also space for women to make additional requests. A caveat statement informing women that their requests will be upheld if at all possible but that, on occasion, extenuating circumstances may prevail is included. The plan is then discussed at women's pre-admission consultation, is 'signed off' by an obstetrician and/or anaesthetist, and is filed in the woman's notes near to other documentation related to the procedure.

An audit of the Scheduled Caesarean Section Birth Plan produced some interesting results. A sample of 150 women were asked if they had or had not chosen to complete the birth plan, why (or why not), and whether they were satisfied with their decision to complete (or not complete) the plan. Those who did choose to complete

the birth plan were also asked if their requests were upheld during their caesarean section, and all respondents were asked how satisfied they were with their birth experience. Finally, women were asked if they had any other comments to make and provided with 10 centimetres of blank space, and were asked to provide a first name and telephone number if they were happy to be called to discuss their responses further.

Eighty-two per cent of those invited to respond did so. The majority of respondents (81%) stated they did choose to complete the birth plan, and in most cases the reason was related to retention of involvement, control and visibility during their childbearing experience. Interestingly, for women who decided not to complete the plan, it was for similar reasons; the comments of these women indicated a preference to remain passive in the experience and to leave all decision-making to the surgeon or the staff.

Intriguingly, although only 23% of women who chose to complete the birth plan reported that their requests had been upheld in the operating theatre, the birth experience was reported as extremely satisfying by 86% of this group. All of the women who responded to this audit survey did provide a telephone number, and all of those who indicated a satisfying birth despite not having their wishes met were contacted. The explanation was almost unanimous: it seemed that women's satisfaction with the birth experience was related to simply being asked what they would like to happen, if possible, during their baby's birth. All but one of the respondents assumed and accepted that the non-fulfilment of their birth plan preferences was due to circumstances that were beyond the staff's control such as personnel shortages and busyness.

What the audit did highlight was that the organisation of midwifery care lets this group of women down. The majority of women who completed the plan indicated that it was very important to them that their family was not separated immediately following the baby's birth, and that they wished to give their baby the opportunity to breastfeed in the first postnatal hour. For the majority of women, however, babies were unable to remain with their mothers in the operating theatre or recovery room because of the non-availability of a midwife to attend them until women's transfer to the postnatal ward. A business case for midwifery care of this group of women to be

provided on a 'follow-through' basis was subsequently developed and submitted, and is currently under review.

To accommodate the initiatives being introduced and reflect the wider evidence from this study about this group of women's experiences, a number of revisions were made to the hospital's clinical practice guidelines (CPGs) related to elective caesarean section. The wording of the majority of the caesarean section CPGs now refer to caesarean section as a birth rather than as a surgical procedure or an operation, and to women and babies rather than patients. The CPGs concerned with antenatal care include reference to providing women with a specific antenatal class, and with offering women an opportunity to complete a Scheduled Caesarean Section Birth Plan. Revisions have also been made to the intra-partum (previously 'intra-operative') CPG, and it now refers to upholding women's documented birth plan requests wherever possible. In addition, a new CPG for the care of the woman having a 'maternal-assisted' caesarean section, borne of Michelle's experience (as reported in Chapter Six of this thesis) has been introduced. The introduction of the 'Planning a Positive Caesarean' antenatal class, the tour of the operating theatre and the scheduled caesarean section birth plan, as well as alterations to the CPGs related to scheduled caesarean section have seemingly begun to engender a cultural change in the operating theatre in relation to the way scheduled caesarean section and women who have them are regarded. Personnel now increasingly talk about the procedure as a birth, and refer to women rather than to cases.

The hospital also now has a 'Next Birth after Caesarean' (NBaC) team of midwives, part of whose remit is to visit women who have had a caesarean section in the first or second day post-natal. The aim of the visit is to support women towards integrating their experience, and to apprise them of their birth options for their next pregnancy. The midwife asks how the woman is, and offers her the opportunity to talk about her experience; s/he also tries to involve partners and/or significant others in these discussions. The midwife answers any questions the woman and/or family has, helps the woman to piece her 'story' together and, where necessary, liaises with the woman's ward midwife and/or medical officer to provide specific obstetric information or advice. Women are also provided with the NBaC service contact number and invited to call should they have any questions or queries over the following six weeks. At this visit, women are also given an information package

containing up-to date information on a broad range of outcomes on caesarean compared with vaginal birth as well as numerous resources and community contacts. Any woman who is clearly very distressed and/or traumatised at this visit is referred immediately to the Department of Psychological Medicine for specialist review and care; they are, however, still provided with information and follow up from an NBaC midwife if desired.

All of the initiatives described above are the subject of ongoing evaluation, and have engendered a number of other research studies that are in progress at the time of writing.

Appendices

Appendix 1. Information sheets for women, partners and staff

Appendix 2. Consent forms for women, partners and staff

Appendix 3. Profile of participant women

Appendix 4. Semi-structured guides for early interviews with women, partners and staff.

Appendix 5. Line diagram of operating theatre for non-participant observational data collection

Appendix 6. MR 290.1: Scheduled Caesarean Section Birth Plan

Appendix 1

WOMEN'S INFORMATION SHEET

Women's Experience of Giving Birth by Medically-Planned Caesarean Section: A Grounded Theory Study

My name is SARA BAYES and I am a nurse, a midwife and a PhD candidate in the School of Nursing and Midwifery at Curtin University.

Pregnancy and childbirth is a normal process that is a significant event in the life of any woman and her family. For some women, however, there is a need to give birth by caesarean to ensure a positive health outcome for themselves and/or their baby.

While research that focuses on the experiences of women who have an unplanned caesarean section after the start of labour and/or in an emergency situation is increasing, very little is known about what it is like for women who have no choice but to have a planned caesarean for a medical reason.

I would like to invite you to take part in a study to help find out how women feel about the decision, and the experience, of birthing by planned caesarean section when recommended for medical reasons. Understanding how women feel about this experience will help midwives and doctors provide the appropriate level of care and support to meet their individual needs.

What is the purpose of the study?

I want to find out how pregnant women who need to birth by caesarean for a medical reason initially feel about this decision, how they feel about the actual caesarean experience and then later, in the postnatal period, how they look back on this experience.

How will the study results be used?

The information from the study will help develop ways to provide emotional support to women who have to give birth by planned caesarean for medical reasons during pregnancy, in theatre during the birth and in the early postnatal period. While this research will not alter the care you receive, we hope it will make a difference to the care of pregnant women in the future.

What is involved in taking part?

If you decide to take part in this study you will be asked to participate in two interviews. The first interview will be before you give birth and the second about ten to twelve weeks after birth. I think each interview will probably take between approximately 60 minutes.

During the first interview, you will be asked for some general information about yourself (for example, what year did you leave school? Have you been working?). You will then be asked to talk about your experience of expecting and having a planned caesarean section for medical reasons. You may be asked some other questions to prompt you occasionally. Following analysis of the interviews, we may need to contact you by telephone to clarify some points.

The interviews will be done at a time that is suitable to you and in a place you feel comfortable with. With your permission the interviews will be audiotape recorded. I will also be asking for permission to come with women to theatre to help me have a better understanding of what it was like for you during the caesarean section operation. What happens during your baby's birth will be observed and documented. I would be an observer only and would not participate in your care.

Do I have to take part?

Your participation in the study is voluntary. If you do not wish to be involved or wish to withdraw at any time you are free to do so. This will not affect the care given to you during your pregnancy, labour or birth, in any way. You can also choose just to participate in the interviews and not to have a researcher present at your baby's birth.

Privacy

All of the information collected about you will remain private and confidential. Only my supervisors and I will have access to your personal details. Any material that may identify you will be removed from your interview transcripts and I will give you a false name or code number. Results of the study will be published in professional journals as a summary of the whole group and contain no identifiable information about you.

Storage of information

All of your information will be stored in a secure location in a locked filing cabinet for a period of 5 years and then destroyed. The master computer file containing personal details will be kept in a separate location to that of the interview data. All files will be password-protected. All data will be managed in accordance with the National Health & Medical Research Council guidelines.

Who has approved the study?

Ethical approval for this study has been granted by the committee for Human Research Ethics Committee at [REDACTED] University and [REDACTED]'s Health Service Ethics Committee.

Who to contact for more information about this study:

If you would like any more information, please do not hesitate to contact myself and/or one of my supervisors for this PhD study, Dr [REDACTED], Associate Professor of Midwifery at [REDACTED] University and [REDACTED], and Dr [REDACTED], Senior Lecturer at [REDACTED] University. Our contact details appear at the end of this information sheet. My supervisors or I would be very happy to talk to you if you have any questions.

SARA BAYES PhD candidate	Tel: [REDACTED] / [REDACTED]
(supervisor 1)	Tel: [REDACTED] / [REDACTED]
(supervisor 2)	Tel: [REDACTED] / [REDACTED]

Who to contact if you have any problems about the organisation or running of the study?

If you have any problems or complaints regarding this study, you can contact the Research Ethics Officer at [REDACTED] University (telephone number ([REDACTED]) [REDACTED]) on a confidential basis or Director of Medical Services at [REDACTED] (telephone number ([REDACTED]) [REDACTED]). Your problems will be drawn to the attention of the Ethical Committee who is monitoring the study.

What to do next if you would like to take part in this research:

If you would like to take part in this research study, please read and sign the consent form provided. PLEASE READ THE FORM CAREFULLY – there are two parts of the project to which you can consent.

THANKYOU FOR YOUR TIME

INFORMATION SHEET FOR PARTNERS

Women's Experience of Giving Birth by Medically-Planned Caesarean Section: A Grounded Theory Study

Pregnancy and childbirth is a normal process that is a significant event in the life of any woman and her family. For some women, however, there is a need to give birth by caesarean to ensure a positive health outcome for themselves and/or their baby. While research that focuses on the experiences of women who have an unplanned caesarean section after the start of labour and/or in an emergency situation is increasing, very little is known about what it is like for women who have no choice but to have a planned caesarean for a medical reason. We would like to invite you to take part in a study to help find out how men feel about the decision, and the experience, of their baby being born by planned caesarean section when recommended for medical reasons. Understanding how men feel about this experience will help midwives and doctors provide the appropriate level of care and support to meet their individual needs.

What is the purpose of the study?

We want to find out how men whose partners need to give birth by caesarean for a medical reason initially feel about this decision, how they feel about the actual caesarean experience and then later, in the postnatal period, how they look back on this experience.

How will the study results be used?

The information from the study will help develop ways to provide emotional support to men whose partners have to give birth by planned caesarean for medical reasons during pregnancy, in theatre during the birth and in the early postnatal period. While this research will not alter the care you receive, we hope it will make a difference to care in the future.

What is involved in taking part?

If you decide to take part in this study you will be asked to participate in two interviews. The first interview will be before your partner gives birth and the second about ten to twelve weeks after birth. We think each interview will probably take between approximately 30 minutes.

During the first interview, you will be asked for some general information about yourself (for example, what year did you leave school? Have you been working?). You will then be asked to talk about anticipating and experiencing the birth of your baby by planned caesarean section for medical reasons. You may be asked some other questions to prompt you occasionally. Following analysis of the interviews, we may need to contact you by telephone to clarify some points.

The interviews will be done at a time that is suitable to you and in a place you feel comfortable with. With your permission the interviews will be audiotape recorded.

If your partner has consented for the research midwife to come with her to theatre, what happens during your baby's birth will be observed and documented. The researcher would be an observer only and would not participate in your care.

Do I have to take part?

Your participation in the study is voluntary. If you do not wish to be involved or wish to withdraw at any time you are free to do so. This will not affect the care given to you in any way.

Confidentiality

Any information that is obtained in connection with this study and that can identify you will remain confidential. Only I will have access to your personal details. My supervisor and other team members will only have access to the de-identified data. Data will be coded and all identifying markers removed from the interview transcripts. Results of the study will be published in professional journals as a summary of the whole group and contain no identifiable information about you.

The results of the analysis will also form the basis of a series of staff development seminars. These sessions will be designed to ensure you are given feedback on the results of the study.

Information storage

All information from this study will be stored in a secure location in a locked filing cabinet for a period of 5 years and then destroyed. The master computer file containing personal details will be kept in a separate location to that of the coded transcribed interview data computer files. All files will be password-protected. All data will be managed in accordance with the National Health & Medical Research Council guidelines.

Who has approved the study?

Ethical approval for this study has been granted by the committee for Human Research Ethics Committee at [REDACTED] University and [REDACTED]'s Health Service Ethics Committee.

Who to contact for more information about this study:

If you would like any more information, please do not hesitate to contact myself and/or one of my supervisors for this PhD study, Dr [REDACTED], Associate Professor of Midwifery at [REDACTED] University and [REDACTED], and Dr [REDACTED], Senior Lecturer at [REDACTED] University. Our contact details appear at the end of this information sheet. My supervisors or I would be very happy to talk to you if you have any questions.

SARA BAYES PhD candidate	Tel: [REDACTED] / [REDACTED]
(supervisor 1)	Tel: [REDACTED] / [REDACTED]
(supervisor 2)	Tel: [REDACTED] / [REDACTED]

Who to contact if you have any problems about the organisation or running of the study?

If you have any problems or complaints regarding this study, you can contact the Research Ethics Officer at [REDACTED] University (telephone number ([REDACTED]) [REDACTED]) on a confidential basis or Director of Medical Services at [REDACTED] (telephone number ([REDACTED]) [REDACTED]). Your problems will be drawn to the attention of the Ethical Committee who is monitoring the study.

What to do next if you would like to take part in this research:

If you would like to take part in this research study, please read and sign the consent form provided.

THANKYOU FOR YOUR TIME

HEALTH CARE PROFESSIONALS: INTERVIEW INFORMATION SHEET

Women's Experience of Giving Birth by Medically - Planned Caesarean Section: A Grounded Theory Study

My name is SARA BAYES and I am a nurse, a midwife and a PhD candidate in the School of Nursing and Midwifery at Curtin University of Technology.

I am conducting a study, using a grounded theory approach, which seeks to describe and theorise the experience of women who need to have a planned caesarean section for medical reasons. While there is an increasing body of evidence investigating women's experiences of *unplanned* or *emergency* CS and those of women who *request* CS for psychosocial reasons, there is very little research exploring and describing how women respond emotionally, psychologically and behaviourally to a CS which is *planned for medical reasons*.

The aim of this study is to increase knowledge and understanding of how women process this experience. To achieve this goal the research will investigate the perceptions women hold about the decision to have a CS and the experience of birthing by CS.

My supervisors for this PhD study are Associate Professor Jennifer Fenwick (Associate Professor of Midwifery at THE HOSPITAL and Curtin University of Technology) and Dr Yvonne Hauck (Senior Lecturer at Curtin University of Technology).

What the study requires of women

Women who need a caesarean section for medical reasons are participating in a study, which will involve two tape-recorded interviews. One interview will take place before birth and the second at approximately eight to ten weeks postpartum. Observational data will also be collected in theatre at the time of the caesarean section with the woman's consent.

What the study requires of staff

To fully understand the woman's experience I would like to talk to an array of health care professionals (such as midwives, nurses and doctors) who have contact with women during their pregnancy and theatre experience. Hence I would like to invite you to participate in a tape-recorded interview. I anticipate that this would last approximately 30-40 minutes and will be informal. I would be happy to do this at a time and place convenient to you. Key questions will be used to guide and stimulate the discussion; however during the interview you will be able to talk freely about topics you feel are pertinent to the subject.

Participation

Your participation in the study is voluntary. If you do not wish to be involved or wish to withdraw at any time you are free to do so. Your decision whether or not to participate in the study will not affect your employment within Kind Edward Memorial Hospital for Women.

Confidentiality

Any information that is obtained in connection with this study and that can identify you will remain confidential. Only I will have access to your personal details. My supervisor and other team members will only have access to the de-identified data. Data will be coded and all identifying markers removed from the interview transcripts. Results of the study will be published in professional journals as a summary of the whole group and contain no identifiable information about you.

The results of the analysis will also form the basis of a series of staff development seminars. These sessions will be designed to ensure you are given feedback on the results of the study.

Information storage

All information from this study will be stored in a secure location in a locked filing cabinet for a period of 5 years and then destroyed. The master computer file containing personal details will be kept in a separate location to that of the coded transcribed interview data computer files. All files will be password-protected. All data will be managed in accordance with the National Health & Medical Research Council guidelines.

Who has approved the study?

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Who to contact for more information about this study:

If you would like any more information, please do not hesitate to contact myself and/or one of my supervisors for this PhD study, Dr [REDACTED], Associate Professor of Midwifery at [REDACTED] University and [REDACTED], and Dr [REDACTED], Senior Lecturer at [REDACTED] University. Our contact details appear at the end of this information sheet. My supervisors or I would be very happy to talk to you if you have any questions.

SARA BAYES PhD candidate	Tel: [REDACTED] / [REDACTED]
(supervisor 1)	Tel: [REDACTED] / [REDACTED]
(supervisor 2)	Tel: [REDACTED] / [REDACTED]

Who to contact if you have any problems about the organisation or running of the study?

If you have any problems or complaints regarding this study, you can contact the Research Ethics Officer at [REDACTED] University (telephone number ([REDACTED]) [REDACTED]) on a confidential basis or Director of Medical Services at [REDACTED] (telephone number ([REDACTED]) [REDACTED]). Your problems will be drawn to the attention of the Ethical Committee who is monitoring the study.

What to do next if you would like to take part in this research:

If you would like to take part in this research study, please read and sign the consent form provided.

THANKYOU FOR YOUR TIME

HEALTH CARE PROFESSIONALS: THEATRE INFORMATION SHEET

Women's Experience of Giving Birth by Medically - Planned Caesarean Section: A Grounded Theory Study

My name is SARA BAYES and I am a nurse, a midwife and a PhD candidate in the School of Nursing and Midwifery at Curtin University of Technology.

I am conducting a study, using a grounded theory approach, which seeks to describe and theorise the experience of women who need to have a planned caesarean section for medical reasons. While there is an increasing body of evidence investigating women's experiences of *unplanned* or *emergency* CS and those of women who *request* CS for psychosocial reasons, there is very little research exploring and describing how women respond emotionally, psychologically and behaviourally to a CS which is *planned for medical reasons*. The aim of this study is to increase knowledge and understanding of how women process this experience. To achieve this goal the research will investigate the perceptions women hold about the decision to have a CS and the experience of birthing by CS.

What the study requires of women

Women who need a caesarean section for medical reasons are participating in the study, which will involve two tape recorded interviews. One interview will take place before birth and the second at approximately ten to twelve weeks postpartum. Observational data is also being collected in theatre at the time of the caesarean section with the woman's consent.

What the study requires of staff

For some of the women in this study, I will be present in theatre during their caesarean section. This will facilitate further exploration of the topic by allowing examination of the interaction and communication processes that occur between women and health professionals during the actual birthing experience. Through the use of hand-written non-participant observation notes, I will document information about the theatre environment and the communications & interactions that take place during the caesarean section. ***As you may be in the theatre at the time of the birth I seek your verbal permission to note down your interactions and movements during the procedure.*** Although interviews and actions may be noted, they will be anonymous – no personal identification of those in the theatre will be recorded anywhere in the data collection. Communication patterns that exemplify the everyday interactions that occur in theatre will be the emphasis of data collection and analysis. ***You are also invited to be interviewed.*** Representatives from midwifery (in the antenatal, intra-partum and postnatal areas), medicine (including anaesthetic consultants, anaesthetic registrars, obstetric consultants, obstetric registrars and obstetric residents) and obstetric theatre staff (including scrub nurses, circulating nurses and anaesthetic technicians) are also invited to participate in an in-depth interview. Interviews will be tape recorded, last approximately 30 to 40 minutes and will be informal. Key questions will be used to guide and stimulate the discussion. You will be asked to talk freely about topics such as your perception of the essential characteristics of the antenatal clinic, theatre and ward environment, important features of working with women and their partners that have to have a planned medically-indicated caesarean section, challenges and rewards working in this area of clinical practice. If you are interested in this aspect of the study please let me know and I will provide you with a second information sheet, contact details and consent form.

Participation

Your participation in the study is voluntary. I will not make any notes of your interactions with the woman if you do not wish me to. Your decision whether or not to participate in the study will not affect your employment within Kind Edward Memorial Hospital for Women.

Confidentiality

Observational data collected in theatre will be de-identified. I will only be making a note of the numbers of people in the theatre, where they are placed at different times and their designation (i.e. nurse, midwife or doctor). No names or personal details will be used when collecting observation data in the theatre. Results of the study will be published in professional journals as a summary of the whole group and contain no identifiable information about you. The results of the analysis will also form the basis of a series of staff development seminars. These sessions will be designed to ensure you are given feedback on the results of the study.

Information storage

All information from this study will be stored in a secure location in a locked filing cabinet for a period of 5 years and then destroyed. The master computer file containing personal details will be kept in a separate location to that of the coded transcribed interview data computer files. All files will be password-protected. All data will be managed in accordance with the National Health & Medical Research Council guidelines.

Who has approved the study?

Ethical approval for this study has been granted by the committee for Human Research Ethics Committee at [REDACTED] University and [REDACTED]'s Health Service Ethics Committee.

Who to contact for more information about this study:

If you would like any more information, please do not hesitate to contact myself and/or one of my supervisors for this PhD study, Dr [REDACTED], Associate Professor of Midwifery at [REDACTED] University and [REDACTED], and Dr [REDACTED], Senior Lecturer at [REDACTED] University. Our contact details appear at the end of this information sheet. My supervisors or I would be very happy to talk to you if you have any questions.

SARA BAYES PhD candidate	Tel: [REDACTED] / [REDACTED]
(supervisor 1)	Tel: [REDACTED] / [REDACTED]
(supervisor 2)	Tel: [REDACTED] / [REDACTED]

Who to contact if you have any problems about the organisation/running of the study?

If you have any problems or complaints regarding this study, you can contact the Research Ethics Officer at [REDACTED] University (telephone number ([REDACTED]) [REDACTED]) on a confidential basis or Director of Medical Services at [REDACTED] (telephone number ([REDACTED]) [REDACTED]). Your problems will be drawn to the attention of the Ethical Committee who is monitoring the study.

What to do next if you would like to take part in this research:

If you would like to take part in this research study, please read and sign the consent form provided.

THANKYOU FOR YOUR TIME

Appendix 2

Code: _____

CONSENT FORM for WOMEN

PLEASE NOTE: PARTICIPATION IN RESEARCH STUDIES IS VOLUNTARY AND PARTICIPANTS CAN WITHDRAW AT ANY TIME WITH NO IMPACT ON CURRENT OR FUTURE CARE.

I, _____

GIVEN NAMES

SURNAME

have read the information explaining the study entitled

**‘Women’s Experience of Giving Birth by Medically Planned Caesarean Section:
A Grounded Theory Study’**

I have understood the information given to me. Any questions I have asked have been answered to my satisfaction.

I understand I may withdraw from the study at any stage and withdrawal will not affect my care.

I agree that research data gathered from the results of this study may be published provided my name is not used.

Please indicate by crossing the box which parts of the study you agree to participate in.

Part 1:

I agree to participate in the audiotape recorded interviews.

Part 2:

I agree to allow PhD student Sara Bayes to attend and take notes during my caesarean section.

Signature _____ Date ____/____/20____

Address _____

Tel. Home _____ alternative _____ mobile _____

Email address _____

code _____

HEALTH CARE PROFESSIONALS' CONSENT FORM

PLEASE NOTE: PARTICIPATION IN RESEARCH STUDIES IS VOLUNTARY AND PARTICIPANTS CAN WITHDRAW AT ANY TIME WITH NO IMPACT ON CURRENT OR FUTURE EMPLOYMENT.

I, _____
GIVEN NAMES **SURNAME**

have read the information explaining the study entitled

**'Women's Experience of Giving Birth by Medically Planned Caesarean Section:
A Grounded Theory Study'**

I have understood the information given to me. Any questions I have asked have been answered to my satisfaction.

I understand I may withdraw from the study at any stage and withdrawal will not affect my employment.

I agree that research data gathered from the results of this study may be published provided my name is not used.

Signature _____ Dated ____ / ____ /200 _____

Ward / department: _____

Contact tel / email address _____

Code: _____

CONSENT FORM for INTERVIEWS with PARTNERS of PARTICIPATING WOMEN

PLEASE NOTE: PARTICIPATION IN RESEARCH STUDIES IS VOLUNTARY AND PARTICIPANTS CAN WITHDRAW AT ANY TIME WITH NO IMPACT ON CURRENT OR FUTURE CARE.

I, _____
GIVEN NAMES **SURNAME**

have read the information explaining the study entitled

**‘Women’s Experience of Giving Birth by Medically Planned Caesarean Section:
A Grounded Theory Study’**

I have understood the information given to me. Any questions I have asked have been answered to my satisfaction.

I understand I may withdraw from the study at any stage and withdrawal will not affect my care.

I agree that research data gathered from the results of this study may be published provided my name is not used.

Signature _____ Date ____/____/200____

Address _____

Tel. Home _____ alternative _____ mobile _____

Email address _____

Appendix 3

Women

	Pseudonym	Age	Gravida, parity	Reason for caesarean (as cited in hospital record)	Partner
1	Cherry	25	G1P0	Breech presentation ('failed' external cephalic version)	Andy
2	Anne	31	G2P1	Low-lying placenta (<1cm from os)	Brian
3	Kylie	38	G1P0	Breech presentation ('failed' external cephalic version)	Colin [^]
4	Rose	26	G3P2	Unstable lie at term(oblique)	Elton [^]
5	Fiona	23	G1P0	'High head' + cord presentation at term	George [^]
6	Madeleine	28	G5P4	Major placenta praevia	Rob [^]
7	Jan	33	G1P0	Gestational diabetes, fundal height consistently 'large for dates'; suspected fetal macrosomia + cephalo-pelvic disproportion	John [^]
8	Yvonne	29	G1P0	Breech presentation	Ethan [^]
9	Donna	31	G3P0	Unstable lie at term(transverse)	Terry [^]
10	Adrienne	35	G3P1	Low-lying placenta (est. 1cm from os)	Jason [^]
11	Jeanne	26	G2P1	'Previous difficult delivery'	Don
12	Steph	40	G1P0		Ed
13	Dee	32	G2P1	Previous myomectomy with classical incision	Gerry [^]
14	Tamsin	41	G1P0		Fiona
15	Jan	27	G1P0	(birth centre)	Aaron [^]
16	Karen	34	G1P0	Unstable lie at term (oblique)	Dave [^]
17	Fleur	30	G2P1	Previous fourth degree perineal tear	Theo [^]
18	Kate	31	G1P0	Previous myomectomy	Lee [^]
19	Keira	25	G3P1	Previous 'difficult instrumental delivery'	Gary
20	Tina	27	G1P0	Genital herpes	Ian
21	Jo	36	G2P0	'High head' at term, previous fractured pelvis / fused coccyx	Kate [^]
22	Trinny	32	G1P0	Previous surgery to	Jed

				cervix with extensive residual scarring.	
23	Sally	24	G1P0	Major placenta praevia	Ken
24	Janine	40	G2P1	Breech presentation ('failed' external cephalic version)	Leo
25	Julia	28	G2P0	Placenta praevia	Mike
26	* Ginny	36	G1P0	Footling breech presentation	Oscar
27	* Pauline	38	G2P1	Previous fourth degree perineal tear	Pete
28	* Michelle	32	G3P2	2x previous CS,	Rob

*Negative cases

^Participant partner

Health care professionals

	Pseudonym	Profession
1	Jane	Midwife (FBC)
2	Jo	Midwife (ANC)
3	Michelle	Nurse (OT)
4	David	Doctor (obstetrician)
5	Tim	Doctor (obstetrician)
6	Mark	Doctor (neonatologist)
7	Many	Midwife (LBS and theatre)
8	Jill	Nurse (OT)
9	Jemma	Nurse (OT)
10	Roland	Doctor (anaesthetist)
11	Steve	Doctor (anaesthetist)
12	Sophie	Doctor (anaesthetist)
13	Helen	Doctor (obstetrician)
14	Hayley	Midwife (ANC)
15	Jill	Midwife (PAC)
16	Angie	Anaesthetic technician
17	Barbara	Midwife
18	Colleen	Nurse (OT)
19	Dave	Anaesthetic technician
20	Jo	Anaesthetic technician
21	Kate	Midwife (PN)
22	Mary	Midwife (PN)

FBC: Family Birth Centre; OT: Operating Theatre; LBS: Labour and Birth Suite; ANC: Antenatal Clinic; PAC: Pre-Admission Clinic; PN: Postnatal ward.

Appendix 4

Initiating questions – Antenatal interviews: women (women)

- What were your childbirth expectations before you became pregnant?
- How has the pregnancy been for you?
- How does this pregnancy compare with any other pregnancy you have had (for women who have previously given birth vaginally)?
- How did you feel about the recommendation to have a caesarean section for the birth of this child?
- How did your partner / family respond to the news of needing a caesarean?
- What was the reason for the decision to do a caesarean?
- How did you feel about the decision at the time?
- Can you describe how you were told of the need to have a caesarean?
- How do you feel now about having a caesarean?
- Do you feel you have been given adequate information
- What do you think the CS will be like?
- What would you like to happen?
- Has anyone asked you what you'd like to happen?
- How do you think you'll feel after the birth?
- Plus issues arising from previous interviews (document below)

Initiating questions - Antenatal Interview: Partners

- What were your childbirth expectations before your partner became pregnant?
- How has the pregnancy been for you?
- How does this pregnancy compare with any other pregnancy your partner (or a previous partner) has had (for men with previous childbirth experience)?
- How did you feel about the recommendation for your partner to have a caesarean section for the birth of this child?
- How did your family and friends respond to the news of your partner needing a caesarean?
- What was the reason for the decision to do a caesarean?
- How did you feel about the decision at the time?
- Can you describe how you were told of the need for your partner to have a caesarean?
- How do you feel now about your partner having a caesarean?
- Do you feel you have been given adequate information?
- What do you think the CS will be like?
- What would you like to happen?
- Has anyone asked you what you'd like to happen?
- How do you think you'll feel after the birth?
- Plus issues arising from previous interviews (note below)

Initiating questions – Staff interviews

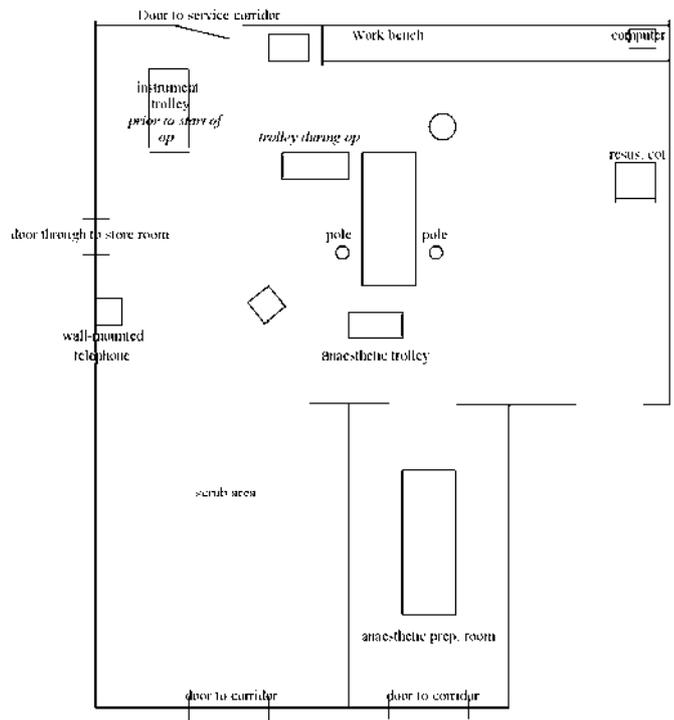
- What are your priorities when you care for women awaiting/having a caesarean section?
- In what ways, if any, does your practice change when you see women who are having an elective caesarean?
- Is there anything you particularly like or dislike about seeing women who are having an elective caesarean?
- What do imagine it's like for women to find out they need an elective caesarean?
- To what extent, if at all, do you discuss women's' feelings (and those of their partner) about needing a caesarean?
- How, if at all, do you discuss ways in which women and their partners can be involved in a caesarean section?
- Is there anything about working in your area that affects your ability to do your job in the way you'd like to?
- Whose responsibility is the emotional care of women who need an elective caesarean section?
- Plus issues arising from previous interviews (note below)

Appendix 5

Interactions in theatre during caesarean section

study ID number:

Date: _____ Time: _____



Appendix 6

<p>WOMEN AND NEWBORN HEALTH SERVICE KING EDWARD MEMORIAL HOSPITAL FOR WOMEN</p> <h2 style="text-align: center;">SCHEDULED CAESAREAN SECTION BIRTH PLAN</h2>	<p>Med Rec. No:</p> <p>Surname: (AFFIX PATIENT LABEL).....</p> <p>Forename:</p> <p>Sex: D.O.B.</p>
<p>It is very important to us that your baby's birth is a joyful, positive and memorable event. To help us make it special, we invite you to complete a birth plan - an outline of your preferences for your care during your baby's birth. <i>If there are no complications during your baby's birth</i> we will use this birth plan as a guide for your care.</p>	
<p>1. My support person in theatre will be:</p> <p>Name: Relationship to me.....</p>	
<p>2. If possible, I would like my support person to stay with me while I have my anaesthetic Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/></p> <p><small>(This is dependent on many circumstances and may not be immediately possible in an emergency situation. If it is not possible your support person will be brought in at the earliest possible convenience).</small></p>	
<p>3. Music:</p> <p><input type="checkbox"/> I don't mind the radio or the staff's choice of music being on in theatre</p> <p><input type="checkbox"/> I will bring my own music CD with me to play in theatre</p> <p><input type="checkbox"/> I don't want any music on while I'm in theatre</p>	
<p>4. If at all possible, you may be invited by the doctor to watch as your baby is born. Please tick your preference</p> <p><input type="checkbox"/> YES - <i>if possible</i> please offer me the chance to watch as my baby is born</p> <p><input type="checkbox"/> NO - I don't want to watch as my baby is being born</p> <p><input type="checkbox"/> I'm undecided about watching as my baby's born - I'd like to decide at the time</p>	
<p>5. If you would like, you can discover your baby's sex for yourself. Please tick your preference:</p> <p><input type="checkbox"/> YES, I would like to discover my baby's sex myself</p> <p><input type="checkbox"/> I don't mind if the staff tell me the baby's sex</p> <p><input type="checkbox"/> I'm not sure - I'd like to decide at the time</p>	
<p>6. As long as your baby is born healthy, the midwife may be able to place him or her straight onto your bare chest ('skin-to-skin'). Please tick your preference:</p> <p><input type="checkbox"/> YES - <i>if possible</i>, I'd like my baby placed skin-to-skin with me</p> <p><input type="checkbox"/> I'd like my baby to be wrapped before I cuddle him / her</p> <p><input type="checkbox"/> I'm undecided about having my baby skin-to-skin with me - I'd like to decide at the time</p> <p><small>(If you DON'T want your baby placed skin-to-skin with you, your baby will be wrapped up warmly and depending on your preference, given to you or your support person to cuddle. <i>You don't have to decide this now; you can let your midwife know at the time</i>).</small></p>	
<p>7. If you will be breastfeeding, you may be able to do this in theatre if your baby shows signs of wanting to. Please tick if this is your preference:</p> <p><input type="checkbox"/> YES - <i>if possible</i> and my baby wants to, I would like to breastfeed my baby in theatre</p>	
<p>8. After the caesarean section it may be possible for you, your baby and your partner / support person to stay together while you go to the recovery area. Please tick your preference:</p> <p><input type="checkbox"/> YES - <i>if possible</i>, I would like my baby and partner / support person to stay with me in the recovery area</p> <p><small>(If this is your preferred option, the staff will try their very best to keep your family together after you leave the operating theatre. Where this is not possible, the reasons will be discussed with you and you will be reunited as soon as possible)</small></p>	
<p>In addition to the choices you have made, we encourage you to write down anything else that is important to you for your caesarean section birth. All of your requests will be carefully considered and discussed with you, and wherever possible, we will accommodate your wishes. If it is not possible, we will try very hard to reach a compromise with you.</p>	
<p>9. Comments / other requests / questions for discussion:</p> <p>.....</p> <p>.....</p>	
<p>My signature:</p>	<p>Date:</p>



MR 290.01 SCHEDULED CAESAREAN SECTION BIRTH PLAN



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